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The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth

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ABSTRACT

Objective: To generate greater awareness of the contextual and relational factors that influence women's capacity to participate in shared decision-making during childbirth.

Methods: A three-phase participatory action research approach involving in-depth interviews and co-operative inquiry meetings.

Setting: Dublin, Ireland in a large maternity hospital.

Participants: Five postnatal women who gave birth to live healthy babies, and attended obstetric or midwifery-led care and 13 practising midwives.

Findings: This paper presents the findings from the third phase of a three-phase action research study exploring the action's women consider necessary to embed informed choice, into practice. The findings reveal that multiple organisational and relational factors influence how women can participate in shared decision-making including the model of care they attended, continuity of carer, power dynamics, hospital policies and trust in self and others. Women's relationships with maternity care professionals reveals that exercising choice is not only defined by but contingent on the degree of trust in their relationships with maternity care professionals.

Introduction and background

Evaluations of maternity care have highlighted what women consider important for them during childbirth. Although differences exist, we know that women want to be informed, and value the opportunity for choice Redshaw et al., (2019). Equally important is continuity of relationship, which is associated with continuity of information, (Jenkins *et al.,* 2015). The importance of the relationship between women and midwives is at the forefront of midwifery research and discussion for over a decade (Perriman et al., 2018, Dalhberg and Aune 2013, Kirkham 2010, Deery and Hunter 2010, Hunter 2008, Walsh 2007). Trust is central to any relationship. International midwifery research reveals themultifaceted importance of a trusting relationship between the woman and midwife, particularly for the emotional aspects of women's birth experiences ((Aune et al., 2012), Leap et al., 2010, Lyberg and Severinsson 2010, Lundgren et al., 2009, Waldenstrøm et al., 2004, Levy 1999).The fact that some women report an association between feeling informed and feeling confidence is a consistent finding internationally (Larkin et al., 2012, Snowden et al., 2011, Dahlen et al., 2010, Hildingsson and Thomas 2007, Hauck et al., 2007).In addition, being informed enables women to understand and subsequently have confidence and trust in the decisions and choices they make with maternity care professionals. This is important because this form of confidence and trust in relationships are stressed as necessary factors for a positive birth experience for women (Dahlberg and Aune 2013). However, repeatedly, women report that midwives and other maternity care professionals are failing to confer trust in their choices during childbirth (Mackenzie Bryers and Van Teijlingen 2010, Dahlen 2010). Women report that instead of supporting choice, professionals choose to support the notions of risk and safety (Coxon et al., 2014, Symon 2006, O'Connor 2006, Beck 2002).

Adding to this, Edwards (2010) suggests that relationships with others can influence women's self-trust in their own capabilities during childbirth. Stoljar (2011) suggests, that individual's identities are formed within the context of social relationships and autonomy should also be, considered in this context.According to McLeod and Sherwin (2000), self-trust reinforces an individual's ability to make decisions. However, self-trust can be diminished in certain circumstances including during childbirth and this can impact on women's sense of autonomy (Leap and Edwards 2006, Edwards 2005, Zadorozynji 1999 Hauk et al., 2007). Empowered individuals are better

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prepared to use their inner resources to confront new situations and become involved in decision-making. However as highlighted by Kennedy et al (2020) although shared decision making in pregnancy, labour, and birth is vital to woman-centred care, practical uptake has been slow. One of the aims of this study was to collaborate with women to seek their perspectives into contextual and relational factors that influenced their capacity to participate in shared decision-making with maternity care professionals during childbirth.

Aim

This research study had three aims: to ascertain the factors that define the construct of informed choice during childbirth. Secondly, to explore women's experiences of choice as expressed through their sense of self. Finally, gain insight into the action's women consider are necessary to embed shared-decision-making, the output of informed choice, into practice.

Methods

This study rests on a participatory worldview, a political statement. The description put forward by Brydon-Miller et al. (2003) resonates closest to the conceptual thinking and design of the study:

> A respect for people and for the knowledge and experience they bring to the research process, a belief in the ability of democratic processes to achieve positive social change, and a commitment to action*to action these are the basic values which underlie our common practice as action researchers'* (p15).

Women's ability to contribute to the development of maternity services in Ireland is limited, compared to countries such as the UK and Australia (Kennedy 2012). Indeed, maternity care policy in Ireland is frequently criticised by women, maternity care professionals, and sociologists who assert that women want more choice, information, and input into the range of services provided to them (Mander and Murphy-Lawless 2013, Kennedy 2012, 2010, 2007, 2002, O'Connor 2006). The study, a three-phase Action Research (AR) was planned and developed to re-dress this imbalance.In the first two phases, one-to-one interviews were held with 15 women to explore their understandings (Phase 1), and experiences of the concept of informed choice (Phase 2) were published previously (O'Brien et al., 2017, 2018). The third phase adopted a co-operative Inquiry (CI) approach, a form of Participatory Action Research (PAR).According to Heron (1996), CI facilitates knowledge creation through active participation of mind and engagement with others. Therefore, it is assumed that knowledge is a source of power and that women generate important and valid knowledge to this area of inquiry (Van Lith 2014, Whitmore, 1994). The objectives of the CI meetings were to collaborate with women, and their birth partners to develop an informational resource to facilitate informed choice and shared decision-making. However, as happens with Action Research approaches, the knowledge and conscious raising that occurred stimulated a change in the original focus of the inquiry. This was a turning point, as women began to look for change, or at the least explanations for the difficulties they experienced. Specifically, from addressing informational difficulties to addressing cultural, relational, and organisational difficulties. Please see Fig.1 below for more details of the three phases of knowledge inquiry and action that occurred.

Setting

The setting for this study is a national referral centre with an annual delivery rate of approximately nine thousand deliveries (8,434 in 2018, 9,400 in 2017). The normal birth rate of 57% is higher than the national average of 53.4% and the overall caesarean section rate of 28.7% is significantly lower than the national rate of 31.2% (Healthcare Pricing Office HPO 2018). Women attending the hospital have the option of choosing from obstetric or midwifery-led care packages of care, including community midwifery. That said, most women attending the unit receive some aspect of the active management of labour package of care.

Table 1
Characteristics of 5 women who participated in co-operative inquiry meetings.

Characteristics	n
Parity	
Para 1	4*
Para 2	1
Age	
30-35	1
36-40	3
41-45	1
Type of Delivery	
Normal delivery	4
Caesarean Section	1 (emergency)
Model of care	
Domino	3**
(Midwifery –led)	2
Consultant-led	
Place of Birth	
Hospital	4
Home	1

**One participant was expecting her second child*
***One attended consultant-led care during their first pregnancy.*

Sample

Healthy women over the age of 18 who gave birth to a live healthy infant in the previous year were eligible to participate. Women under the age of 18 years of age and those whose spoken English prevented them achieving written informed consent were excluded. Following ethical approval and assistance from midwives, women were recruited from postnatal wards, postnatal baby-clinics, community midwives postnatal support groups and breastfeeding support clinics. Women interested in participating were given oral and written information about the aims of the study as well as the terms of confidentiality. 15 women agreed to participate in each of the three phases of the study however, only five women from the original 15 participated in phase three due to work and family commitments see Table 1 for further details. Because of the sensitive nature of the topic, a support mechanism for debriefing by a bereavement midwife specialist was included into the study design. However, there were no requests for additional supports services throughout the course of the study.

Data collection

"Creating the Time and Space to Listen to Women"

The study was approved by the Ethics committee of the research site and University College Dublin. Phase three consisted of nine CI meetings over 18-months held in the hospital at 7pm, to facilitate childcare needs of women. All meetings were recorded, and women were provided with copies of the transcripts. Transcripts and agreed actions were also reviewed and confirmed by the group at the beginning of each meeting.Prior to engaging in the study, women had believed their difficulties were unique to them, however, reflecting with others highlighted their shared experiences. Together women questioned cultural, organisational, and relational difficulties they experienced and agreed maternity care professionals' perspectives were needed. Women wanted midwives' insights and declined the offer to include Obstetricians into the inquiry process. Subsequently ethical approval was sought and gained to

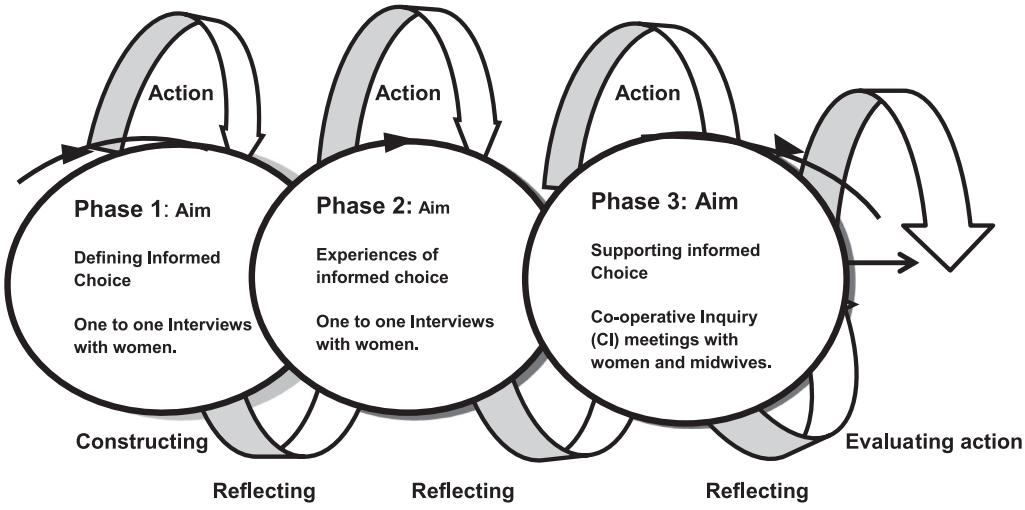

Fig. 1. Three phase action research inquiry.

include midwives in the study. Midwives were provided with information about the study and the purpose of collaborating with them which was to gain their' insights about 1) informational support needed, 2) organisational and cultural barriers that existed 3) their perspectives on possible solutions. Subsequently 13 midwives agreed to participate, two meetings occurred one with 13 midwives and a second with 5 women and 6 midwives. See Table 2 for more details of the meetings.

Analysis

The data analysis for the CI meetings were analysed using qualitative content analysis. The software package NVIVO 9 was used to support the data analysis process. Each transcript was transcribed by the researcher to maximise the level of engagement with the data. Prior to coding transcripts was read numerous times. . A coding frame was developed and was generated in a manner that was both concept-and data-driven. The approach recommended by Mayring (2014) and Schreier (2012) was adhered to when generating the coding frame. Firstly, concepts from the topic guide from the CI meetings were used to generate and structure the coding frame. The topic guide was developed from the findings of the interviews conducted with women during the first phase of the study. Secondly, themes emerging from the discussion generated at each CI meeting were added to the coding frame. The method selected to code the data was open coding. Similar nodes were coded together as a theme or subtheme and the relationship between themes and subthemes were examined and sorted into categories. Some themes were reviewed and changed to subthemes. Some themes and subthemes were moved to a different category that was considered more relevant. This was conducted to ensure that: 1) all the relevant data was coded, and 2) there was no duplication of themes amongst the different categories. The original transcripts were also used during this process to ensure none of the relevant data had been lost during the coding process. Forty-one initial sub-themes emerged from the 89 nodes coded, these were then reduced to eight categories and, following further analysis, were reduced to four key categories. The analysis was conducted by DOB, MB and MC reviewed the data and provided analytic input throughout the process.

Findings

A large amount of rich data was generated from the CI meetings with women and midwives and the findings are presented thematically. To present the data from each meeting in a chronological manner would have been confusing and repetitive, however the meeting number is indicated throughout the findings. To protect confidentiality, pseudonyms have also been used throughout. First-time mothers and second-time mothers attributed equal importance to the need to for change. However, second-time mothers provided more varied descriptions in terms of the type of delivery, the model of care, and their relationships with maternity care professionals, because they had more experiences of maternity services to draw on. To reflect this, the findings are presented in a manner that identifies the parity of each participant. The following themes reveal how changing the culture and power dynamics thatexist within relationships between women and maternity care professionals are integral to embed shared decision-making during childbirth in Ireland.

They have a different plan for you

A recurrent theme was that participating women had a genuine fear that their autonomy could be compromised in the hospital setting. The birth stories of friends and family appeared to be the most influential factor to this belief, as indicated by the following statement:

> *You know you go in, and you become institutionalised as soon as you go in the door. I was a bit nervous about that, that power and autonomy would be compromised, particularly your first birth your nervous you know, what you hear from your friends and family you always hear the bad stories…*
>
> (M3 Rose para 1)

It transpired that there was considerable variation in the amount of autonomy and subsequent choices that each woman was afforded. The 3 women who chose a midwifery-led model of care experienced greater personal attention and reported an increased potential for autonomy. For example, Erin suggested that attending midwifery-led care provided a space that encouraged her to listen to her intuition:

> *You know they give you the confidence to trust your own instincts it was such an empowering experience you know they give you that space to make your own choices and they support you throughout it…*
>
> (Erin para 1)

Rose spoke about the relationship she developed with domino midwives, how she felt about herself in this relationship and how she communicated with them as a result as indicated below:

> *I felt that they were very open to talking and you didn't feel rushed in any of my appointments… I felt you could ask them anything and they never made you feel stupid you know it was that kind of relationship… they were very kind really…* (Rose Para 1)

Table 2
Overview of co-operative inquiry group meetings.

Meeting no.	Participants	Agreed Purpose/aims of Meeting	Actions and outcomes
Meeting 1	5 women &Researcher	Agree roles and responsibilities Begin development of information pack. Review definition of informed choice.	Initial chapters decided. Women agreed to contribute their stories andreview informational resources available.
Meeting 2	5 women &Researcher	Review actions undertaken Continue to agree content	Headings and sections for pack agreed.Relational and organizational barriers toinformed choice identified. Generatedawareness of the inconsistencies that exist in 'the system'.
Meeting 3	5 women & Researcher	Review actions undertaken Continue to agree content andreview collated information to date.	Midwives perspectives requested about drafted information pack and relational and organizational barriers.
Meeting 4	13 midwives & Researcher	Review pack and consider women's difficulties exercising choice	Midwives considered drafted pack useful. Midwives unaware of many of women'sdifficulties and felt powerless and unsupported to initiate necessary changes.
Meeting 5	5 women & Researcher	Update from midwives meeting Continue to develop information pack	Meeting requested with midwives to discuss relational and organizational barriers experienced by women.
Meeting 6	5 women 6 midwives & Researcher	Explore the supports necessary to support Informed choice	Women engaged in dialogue with midwives and considered the actions necessary to support choice. Midwives agreed to undertake someinitiatives to address some of the issues raised by women.
Meeting 7	5 women & Researcher	Agree final content of theInformation pack. Confirm finaldefinition of informed choice.	Women agreed to contribute more pieces to the information pack. Definition agreed for informed choice.
Meeting 8	5 women & Researcher	Make final suggestions and evaluate the information pack	One woman's information contributionevaluated. Deadline set for remainder ofcontributions.
Meeting 9	5 women & Researcher	Evaluate the information pack	Feedback received on Final draft of pack. Reflection on the benefits gained from participating in the study. Agreement to offer informational resource developed to whatsupmum.ie.

In contrast omen who attended public obstetric-led care suggested that, once they entered the domains of the hospital, their ability *to be* autonomous completely changed, as indicated in the following statement:

> *Even if you feel you have made certain choices when you go into the hospital, they have a different plan for you do you know what I mean…*
> (M6 Lisa para 1)

One woman described her experiences as 'being institutionalised' as indicated in the following statement:

> *You know when you are in a hospital situation you are immediately institutionalised. You know, no matter if you are the most confident person in the world, once you are in with a nametag and in your nighties, you are not best placed, particularly after having your first baby you know you are not able to stop and say sorry this is not right… and be the adult you would be out in the world…*
> (M3 Rose para 1)

Participating midwives also raised concerns about the amount of autonomy women were offered, as indicated in the following statement:

> *There are huge barriers to autonomy, it depends who they are asking the question too… it is so individual even amongst individual doctors and midwives. The choices each woman can make there is absolutely nothing set in stone about choice…It is really who you meet on the day and their choices….*
> (M4 midwife 4)

One of the features of the hospital that appeared to significantly diminish women's autonomy was hospital policies as indicated below:

> *I attended the community midwives for my second pregnancy. I had a choice but at my first birth the midwife ruptured my waters. I did not have a choice she said it was the policy you know, I did not know that I could have said no, well that was not my perception at the time and to be honest this was the reason I went for a homebirth the second time, so that I could have some sort of control over the way my birth went…*
> (M6 Brona para 2)

Women suggested that some midwives appeared to hold an allegiance to hospital protocols or policies rather than the woman's individual choices. Women believed this equated to less choice for women. It seemed the individual philosophy of the midwife may influence the choices she offers women, as indicated in the following discussion by participating midwives with women:

> *Yea well amniotomy is a policy we practice here, they found that if you have clear waters, we do not need to monitor the baby. So, we know all is ok, so that is another reason for it, then they found that it quickens your labour…*
> (M6 Midwife 5)

> *But it is not organic, it is not natural, someone breaking your waters is like two bricks rubbing against each other so taking that protection away, you know nature is doing that for a reason…*
> (M6 Midwife 9)

You do not have the same power to make decisions

It was the belief of each of the participating women that obstetricians and midwives were in a more powerful position than women and this ultimately led to diminished autonomy for women, as indicated by the following statement:

> *You know you do not have the same power in the equation, unless you say I am a taxpayer and I do have the power and you are quite political about it but when you are pregnant you seem to accept that…*
> (M6 Rose para 1)

One woman suggested that the phraseology and language used by obstetricians portrayed women in a less powerful position:

> *I thought from reading what I read going in that they would just decide to use forceps should things be not going as they should, and I would not really get an option and I would get a forceps and all sorts of terrible things. I thought I did not have an option it was like no, no, no, it's not a question of, do you? It was a question of you do, I know these things and I am telling you well that is how I interpreted it …* (M1 Lisa para 1)

Participating midwives acknowledged and re-affirmed women's beliefs about the power dynamics that existed and considered it led to an inequality developing in the relationship and described the impact this can have on women:

> *You know they do not want to come back again and you know it goes the whole circle we get patients from other hospitals and they get patients from us you know it is not unique to us it is a common denominator in all the labour wards in (names city) …* (M5 Midwife 6)

Women's experiences led them to believe that midwives are overburdened working in Irish maternity services and this they believe resulted in some midwives becoming desensitized to the needs of women as indicated below:

> *I feel it is because of lack of resources, because the midwives have x number of people going through the system, they become desensitized to the individual because of the numbers flying through. You are not relating to the person in front of you and you have your professional face, and you are not engaging with the person in front of you know. This is the next process I must go through almost like someone else goes through invoices…*
> (M6 Rose para 1)

Agreeing on control

Each of the participating women described that it was important to them that they remained 'in control' during their experience. Threaded throughout these discussions was a belief that control was subjective and unique to each woman:

> *The thing with control is some people want complete control over it… others want to hand it over…*
> (M2 Nicola para 1*)

Participating women's accounts highlighted the authenticity of this statement:

> *I have to say the midwife that I got was fantastic and I know she was older than me and I kind of just felt she was totally in control and that was great and ehm I suppose I was not really worried I was happy that she took control of the situation…*
> (M2 Erin para1)

> *In terms of control, I was not happy to just hand that over to them I wanted to be the one that controlled how the birth went…*
> (M2 Brona para 2)

When women spoke about their fears of loss of control, they mainly spoke about fears of loss of external control. These fears were bi-dimensional. Firstly, participating women feared they would have no control over the use of interventions, as was the case for this woman:

> *I know from what I read I felt threatened by the idea of induction I wanted to have some control over how it went…*
> (M2 Brona para 2)

Secondly, participating women feared that their beliefs and values may not coincide with those present at their birth:

> *Yes, I know I had heard so many bad stories from my friends who felt they had no control over how the birth went. So not loss of control in the physical sense but more the institutional sense, that really made me afraid that I would have no say or input into my own birth you know that it would be how they wanted it to go…*
> (M2 Rose para 1)

When women shared their concerns with midwives, the complexity of the problem emerged:

> *Women must understand that at the end of the day they cannot control it we need to take control at the end of the day we are the ones that are accountable…*
>
> (M6 Midwife 2)

> *The problem with control is that everyone needs to feel in control that is what we need to figure out how to make that happen…*
>
> (M6 Midwife 4)

The group suggested that what was needed was a balanced reciprocal approach to control with both parties respecting each other's needs. The starting point was promoting a dialogue that was honest and open in its approach between women and their carer during labour. This, the group agreed would facilitate a more balanced approach to the issue of control that could emerge during pregnancy and childbirth.

Developing a culture of trust

This theme consists of a synopsis of how the concept of trust and issues surrounding trust in relationship and in 'the system' influenced women when they were making choices for childbirth. Women suggested that trust formed part of the basis of which they made informed choices, as indicated in the following statement:

> In the back of your mind, you are trusting that these professionals have the best interest of you and your baby at heart, so you must invest in trust and give something to the system…
>
> (M3 Rose para 1)

When midwives spoke about trust, the relationship was a focal point of the discussions, as indicated in the following statement:

> I suppose if there was only one word, I would ask women to develop its trust … I think it is the one word that is essential to support choice…trust us…
>
> (M4 Midwife 5)

It seemed that participating women did trust midwives and an expressed belief and trust in the knowledge and skill of midwives was a recurrent theme discussed by women. What was different was how participants spoke about the development of this trust. For some, it seemed that it was a realisation or an acceptance from their experiences; for others it seemed to be connected to a relationship, as indicated in the following two statements:

> I did come to realize you know two or three days into my stay here well you know this is it… I am here until the baby is born and I am just going to have to trust whoever is around me whatever is going to happen is going to happen…
>
> (M3 Nicola para 1*)

> *I had seen her several times during my pregnancy, and I went yahoo when she came into the room, so when she suggested I had an episiotomy I was happy to go with that choice even though all along I had wanted to avoid one, but I knew she would only do it if she had to, I completely trusted her…*
>
> (M3 Rose para 1)

Continuity of carer seemed to be pivotal to the quality of the relationship developed. One woman's description highlighted how continuity of carer enhanced her relationship with her midwife and her subsequent approach to conferring trust to this midwife. This was a recurrent theme, participants described that their decision to trust professionals was influenced by the connection or relationship they had developed, as indicated below this:

> I had seen her throughout my pregnancy, so I trusted her. I knew she would make choices that were for me and not about the institution if you know what I mean…
>
> (M3 Erin para 1)

> He (obstetrician) gave me his plan and I was happy with that. I had gotten to know him over the pregnancy, and I *had a good relationship with him, and I was happy. That helps you trust them when it comes to the birth and the decisions, they make you trust them…*
>
> (M3 Nicola para 1*)

Parallel to the trust that women conferred to individual professionals was an overriding description of the lack of trust they had in 'the system' of maternity services. Participants suggested their previous birth experiences and the experiences of their friends and family were fundamental to their beliefs about conveying trust in 'the system' as indicated in the following statement:

> *It's sad really but my reluctance to trust doctors was because of my first birth experiences but also the stories of my friends not what you want to hear…*
>
> (M3 Brona para 2)

Women's descriptions suggested that their choice was connected to their philosophy of childbirth as indicated in the following statement. Participating women suggested some women choose to put their trust in doctors, while some women prefer to bestow trust to midwives:

> *I felt that there is a level of experience a medical appreciation of all that can happen and the knowledge and support and experience to deal with those situations. If they happen you know you trust them (midwives), and you know it's not that I am medically adverse, but I just felt that people have being doing this for millennia…*
>
> (M3 Rose para 1)

> *And there are women out there that are like, no way do I want a midwife I want a consultant, and these are women who feel that it is not safe, they feel you need to go to the doctor when you are pregnant…*
>
> (M3 Erin para 1)

Threaded throughout these discussions was the influence of women's internal trust in their capabilities to give birth. It seemed that this trust influenced women's philosophy for birth and the professionals they awarded trust to during childbirth, as indicated in the following statement:

> *I have a friend and she kept saying I would not be able for it… I am asking for a section… and I kept saying to her why? What part of it? It is just the most amazing feeling afterwards, but she did not trust her body…*
>
> (M2 Nicola para 1*)

Much of the difficulty participants described about conferring trust to professionals were related in some manner to the way they communicated with women, as indicated in the following statement:

> *I said I would not write anything down, I thought I could just say what I wanted, but she came in and just took over. It felt like I had no choice, you are trusting these people are making decisions in your best interests, but I felt railroaded by this midwife and that affects how you trust the next midwife that comes along but thankfully she was lovely…*
>
> (M3 Lisa para 1)

Midwives also agreed that trust can be lost in the relationship between women and midwives and the reasons can be attributed to the way midwives communicated with women:

> Yea they get afraid of the staff they do not trust the staff. They do not get to build up a rapport when that happen. A first baby is a very traumatic situation, and it's how you give the information across to women, like saying this is where we are at, so they can be involved in

the decisions because they know what is happening it so important to build that trust…

(M4 Midwife 5)

Once again, continuity of carer was suggested to negate these difficulties and promote trust.

Discussion

This study presents new findings about women's relationships with maternity care professionals and the culture that exists in contemporary maternity care in Ireland. Discussing the significance of context to developing reciprocal relationships, Deery and Hunter (2010) suggest that large maternity hospitals are less likely to enhance reciprocal relationships. Similar concerns have been raised in Ireland, by Begley *et al.,* (2009) and Larkin et al., 2012). The culture reported by women and midwives in this study supports these assertions. It was clear from women's accounts that fear about loss of autonomy in the hospital environment was common. Indeed, the findings highlighted these fears were well-founded, as women's ability to be autonomous were disproportionate and contingent on both the relationship they developed from their preferred model of care. . These findings build upon what is already known about the way disparities in maternity care provision and work force shortages impinge on the degree of autonomy women can exert during pregnancy and childbirth (Noseworthy et al., 2013, Hunter 2006,Leap and Edwards 2006, Edwards 2005, Zadorozynji 1999 Greene et al., 1998, O'Cathain et al., 2002, Thachuk 2007). In addition to the culture that exists, the findings clearly demonstrated that women's experiences of autonomy were influenced by the individual beliefs and agenda of professionals and as a result were subjective. It is Thachuk's (2007) assertion that midwifery models of care offer a perspective from which this can be realised by integrating relational approaches to autonomy within the maternity care context. The findings of this study support this assertion, as a significant finding was that three women who chose midwifery-led models of care experienced greater personal attention and reported an increased potential for autonomy; again, women attributed this to the relationship they developed.

According to Hunter (2008) relationships are the hidden tapestry of maternity care. The findings of this study have substantiated this assertion and, in addition, revealed that, in the same manner, trust is a hidden but important fibre in the process of informed choice. The international evidence reveals trust is an important aspect of maternity care delivery and develops in response to social interactions between individuals and groups and has been described as a relational phenomenon (Rocca-Ihenacho et al; Noseworthy et al., 2013; Theide, 2005). Perriman et al., (2018) identified "trust" as a key component of the midwifery continuity of care model valued by women. The development of a relationship between a midwife and woman facilitates development of trust.

In the context of this study, the importance of trust to the process of informed choice was noted in three distinct but inter-related ways: trust in self, trust in relationship, and trust in the system. Like the findings reported by Edwards (2010) and Madi and Crow (2003), trust, in self, influences the choices women make during pregnancy and childbirth. It seemed that women, who had an enhanced sense of trust in their own capabilities, were 'more confident' to make autonomous choices for themselves and were less influenced by cultural and medical ideologies. Factors that influenced self-trust included previous birth experiences, age and the quality of relationships developed with maternity care professionals. Like findings reported by Viisainen (2001) in Finland, self-trust stemmed from personal experiences and trust in intuition. Although a notable finding in this study, trust in self was not a static entity and was influenced and dependent on both context and relationship. Numerous studies show that a trusting relationship between a woman and her midwife is important for the emotional aspects of their birth experiences (Rocca-Ihenacho et al; Dykes 2009; Hunter 2009; McCourt et al., 2006; Waldenstrøm et al., 2004; Lundgren et al., 2009, Leap et al., 2010; Lyberg and Severinsson, 2010; Aune et al., 2012).

This is supported in the findings of this study, as women who reported positive relationships reported how 'trust in this relationship' enabled them to make decisions for themselves. This finding builds on previous work by Parrett (2010), MacDonald (2001), and Anderson (2004) suggesting that women who can build up a trusting relationship are more likely to report the self as 'an active subject' during the events of their birth. Central to women's narratives in this study was how they experienced trust as a reciprocal process. Maternity care professionals (community midwives and one obstetrician in this case) trusted in the physiological process of birth and the ramification of this was that women subsequently felt supported and trusted to remain in control. Subsequently, they expressed this clearly through a positive and enhanced sense of self. Women's reported sense of self following childbirth is relatively unknown in the Irish context and findings that trusting relationships enhances women's ability to exercise choice but also their sense of self is an important one. This has been reported elsewhere by Noseworthy et al., (2013), and Leap et al., (2010), both finding that women linked trusting relationships developed with midwives to the way midwives shared information and discussed choices with them. This highlights the important interdependency between the provision of quality communication and information to the development of trusting relationships between women and their care giver. This was also noted by Dahlen et al. (2010), who found women learnt to trust in the skills of midwives through the process of receiving information from them. The importance of interdependency or mutuality in relationship is discussed by Allgood and Kvalsund (2005). This form of relationship is characterized by trust and is a measure of psychological confidence according to Rogers (1961) and this was clearly visible in women's accounts. Like the reports by and Noseworthy et al. (2013) and Homer et al. (2012), trust was also linked to advocacy. Women who felt informed trusted in the decisions of their carer and were willing to hand over decision-making to midwives particularly during labour. This, again, highlights the importance and interdependency of trusting relationships to the process of informed choice, and is reported elsewhere by Leap et al., (2010), Edwards (2010), Berg et al., (1996), Bluff and Holloway (1994).

Women who felt less supported to make informed choices, spoke negatively about the degree of trust they experienced in relationships. Lack of quality in relationships has been attributed to women's fear of childbirth and lack of trust by Waldenstrøm et al., (2004) and Nilsson and Lundgren (2009). Indeed, the need for greater trust in relationships was a recurrent theme in the current study and, like that reported by Hunter (2006), a clear distinction was noted by midwives between hospital and community environments in relation to the establishment of meaningful and trusting relationships. A key finding in this study was that constraints of time influenced the quality of the trust that developed, and the relationship women established with maternity care professionals. This finding confirms and builds on the findings by Boyle (2013), who found that a fundamental issue to support women to develop a trusting relationship was the need for adequate time. Based on the findings of her study exploring women's experiences of homebirth in Scotland, Edwards (2005) asserts that the climate of trust can be disturbed by a system of care that devalues relationships. The findings of the current study provide further evidence to support this perspective. In the same manner, lack of trust and devaluing the importance of relationships has also impacted significantly on women's confidence in 'the system' of maternity services and individual maternity care professionals in the current context. Therefore, there is a clear need to value the importance of developing quality relationships between women and their chosen caregiver during childbirth in Ireland.

Limitations

The limitations of this study relate mostly to the fact that the recruitment of participants was confined to one maternity hospital, which

limits the application of findings beyond this specific context. In addition, most participants were articulate middle-class women and well-educated and further research is required to explore the experiences and expectations of women from other backgrounds in relation to informed choice. In particular marginalized and underrepresented groups as we know their voice is necessary for birth justice.

Recommendations for practice

There is a need to consider the significance of what 'being informed' entails for women. The findings of this study have highlighted both relational and organisational difficulties that exist and these need to be acknowledged in maternity care policyfor informed choice to move from rhetoric to reality. This study has revealed the shortcomings that exist in the relational aspects of care that women receive associated with staff shortages, time constraints and pressures on 'the system'. This needs to be actively pursued and rectified by maternity care policymakers. The findings have identified a need for the introduction of a shared-decision-making framework for maternity care. Introducing a national framework could foster an environment that supports autonomy for women regardless of the model of care they attended. Education of care providers is also recommeded consideringthe wide variations reported by women from different providers. In addition, informed choice and shared-decision making should be considered as important performance indicators when evaluating standards of maternity care.

Ethical Approval

Ethical approval was granted by both the research site and University College Dublin.

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There was no conflict of interest.

CRediT authorship contribution statement

Denise O'Brien: Conceptualization, Methodology, Investigation, Resources, Writing - review & editing, Funding acquisition. **Michelle M. Butler:** Conceptualization, Methodology, Software, Validation, Investigation, Resources, Writing - review & editing, Supervision, Project administration, Funding acquisition. **Mary Casey:** Formal analysis, Visualization, Writing - review & editing, Project administration.

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