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Women’s Lived Experience of Compassionate Midwifery

By

Diane Ménage

April 2018

A thesis submitted in partial fulfilment of the University’s requirements for the Degree of Doctor of Philosophy
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<td>Faculty:</td>
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<td>Diane Ménage, Elizabeth Bailey, Susan Lees, et al</td>
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Certificate of Ethical Approval

Applicant:

Diane Menage

Project Title:

Compassionate Midwifery: appreciating, describing and understanding women’s lived experiences of compassion

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

21 March 2016

Project Reference Number:

P40087
Dear Ms Menage

Study title: Compassionate Midwifery: appreciating, describing and understanding women's lived experience of compassion.
IRAS project ID: 203024
Protocol number: N/A
REC reference: 16/NI/0066
Sponsor Coventry University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read Appendix B carefully, in particular the following sections:

- Participating NHS organisations in England – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- Confirmation of capacity and capability - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.
Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices
The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval
The document “After Ethical Review – guidance for sponsors and investigators”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the After Ethical Review document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope
HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.
User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training
We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is 203024. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen
Assessor

Email: hra.approval@nhs.net

Copy to: Dr Elizabeth Bailey (Sponsor contact)
          Ms Sonia Kandola, Research, Design and Innovation, University Hospital Coventry and Warwickshire (Lead NHS R&D contact)

Participating NHS organisations in England
## Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

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<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>Confirmation of any other Regulatory Approvals (e.g. NIGB) and all correspondence [CU ethics approval-document]</td>
<td>1</td>
<td>29 March 2016</td>
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<tr>
<td>Copies of advertisement materials for research participants [Version 01 Poster]</td>
<td>1</td>
<td>29 February 2016</td>
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<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Liability Insurance CU]</td>
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<td>29 March 2016</td>
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<td>Interview schedules or topic guides for participants [Version 01 Interview Schedule 290216]</td>
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<td>29 February 2016</td>
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<tr>
<td>IRAS Application Form [IRAS_Form_04042016]</td>
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<td>Other [Schedule of Events]</td>
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<td>Other [Statement of Activities]</td>
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<tr>
<td>Other [Version 01 Leaflet]</td>
<td>01</td>
<td>29 February 2016</td>
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<td>Other [S Lees CV]</td>
<td>01</td>
<td>04 April 2016</td>
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<tr>
<td>Other [E Bailey CV]</td>
<td>01</td>
<td>04 April 2016</td>
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<tr>
<td>Participant consent form [Version 01 Participant Information and Consent 290216]</td>
<td>01</td>
<td>29 February 2016</td>
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<tr>
<td>Participant information sheet (PIS) [Version 01 participant information and consent 290216]</td>
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<td>29 February 2016</td>
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<tr>
<td>Research protocol or project proposal [Version 1 Research Protocol for ethics 290216]</td>
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<td>29 February 2016</td>
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<td>Summary CV for Chief Investigator (CI) [Summary CV Diane Menage version 1]</td>
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<td>29 March 2016</td>
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<td>Summary CV for student [Summary CV D Menage version 1]</td>
<td>1</td>
<td>29 March 2016</td>
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<td>Summary CV for supervisor (student research) [Jane Coad summary CV IRAS 203024]</td>
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Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, participating NHS organisations, capacity and capability and Allocation of responsibilities and rights sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study: Dr Elizabeth Bailey (email- ab8132@coventry.ac.uk, telephone- 02477659907).

HRA assessment criteria

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<td>1.1</td>
<td>IRAS application completed correctly</td>
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2.1 Participant information/consent documents and consent process | Yes | Participants who are not being interviewed face-to-face will give consent prior to the interview, either by posting or emailing the signed consent form to the researcher. Participants will be informed of this when they are contacted by the researcher to arrange the interview. |

3.1 Protocol assessment | Yes | No comments |

4.1 Allocation of responsibilities and rights are agreed and | Yes | The Statement of Activities will act as the only agreement between the |
<table>
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<th>Compliant with Standards?</th>
<th>Comments</th>
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<td></td>
<td>documented</td>
<td></td>
<td>sponsor and participating organisations. Although formal confirmation of capacity and capability is not expected of all or some organisations participating in this study (see <em>Confirmation of Capacity and Capability</em> section for full details), and such organisations would therefore be assumed to have confirmed their capacity and capability should they not respond to the contrary, we would ask that these organisations pro-actively engage with the sponsor in order to confirm at as early a date as possible. Confirmation in such cases should be by email to the CI and Sponsor confirming participation based on the relevant Statement of Activities and information within this Appendix B.</td>
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<td>4.2</td>
<td>Insurance/indemnity arrangements assessed</td>
<td>Yes</td>
<td>It has been confirmed that Coventry University insurance will cover the design of the research and that NHS insurance was selected in error (IRAS A76-1). Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study</td>
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<td>4.3</td>
<td>Financial arrangements assessed</td>
<td>Yes</td>
<td>No funding will be provided to sites.</td>
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<td>Compliant with Standards?</td>
<td>Comments</td>
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<td>No comments</td>
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<td>5.2</td>
<td>CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed</td>
<td>Not Applicable</td>
<td>No comments</td>
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<td>5.3</td>
<td>Compliance with any applicable laws or regulations</td>
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<td>No comments</td>
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<td>6.1</td>
<td>NHS Research Ethics Committee favourable opinion received for applicable studies</td>
<td>Yes</td>
<td>REC Favourable Opinion was received on 12\textsuperscript{th} April 2016.</td>
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<td>6.2</td>
<td>CTIMPS – Clinical Trials Authorisation (CTA) letter received</td>
<td>Not Applicable</td>
<td>No comments</td>
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<tr>
<td>6.3</td>
<td>Devices – MHRA notice of no objection received</td>
<td>Not Applicable</td>
<td>No comments</td>
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<tr>
<td>6.4</td>
<td>Other regulatory approvals and authorisations received</td>
<td>Not Applicable</td>
<td>No comments</td>
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**Participating NHS Organisations in England**

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site-type. Interviews may take place at participating organisations. Posters advertising the research will be placed in antenatal and prenatal wards and antenatal clinics and classes taking place at participating organisations. Midwives will give leaflets advertising the research to patients discharged from midwifery care in the postnatal period.
Some participants may also be recruited outside the NHS. HRA approval does not cover activity outside the NHS. Before recruiting outside the NHS the research team must follow the procedures and governance arrangements of responsible organisations.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

**Confirmation of Capacity and Capability**

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England are not expected to formally confirm their capacity and capability to host this research because interviews will be undertaken by the research team. Participating organisations will be required to display study posters and distribute study leaflets when providing routine paperwork to patients who have been discharged from midwifery care.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- It is expected that these organisations will become participating NHS organisations 35 days after the date of issue of this letter (no later than 23rd May 2016)
  - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate
  - You may not include the organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed.
  - You may not begin the research at any participating NHS organisation in England until a Letter of HRA Approval has been issued.
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed, and a Letter of HRA Approval has been issued.

The document “Collaborative working between sponsors and NHS organisations in England for HRA”
Approval studies, where no formal confirmation of capacity and capability is expected* provides information for the sponsor and NHS organisations on working collaboratively with NHS organisations in England where no formal confirmation of capacity and capability is expected, and the processes involved in adding new organisations.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator is required to facilitate circulation of posters and leaflets advertising the research and to facilitate room bookings where central study staff will be present at the NHS organisation to undertake research procedures. No formal training will be required.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken.

A Letter of Access will be required for the researcher to conduct interviews on NHS premises with patients. Disclosure and Barring Service and Occupational Health checks will be needed where a Letter of Access is required.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.
Dedication

I dedicate this thesis to Carolynne Craig, a special, courageous woman whom I had the privilege of supporting when she had her son Lochie. She taught me something very important about midwifery which, on reflection, must have sown the seeds for this work.
Abstract

Background: Compassion is held up as an important aspect of quality healthcare. In the UK this has facilitated considerable discussion, analysis and research into compassion. However, there has been a dearth of research into compassion related to midwifery care. This thesis addresses that omission by analysing what is meant by compassionate midwifery and by examining women’s lived experience of receiving compassion from midwives.

Methods: An evolutionary concept analysis sought to ascertain the meaning of compassionate midwifery. A qualitative study was conducted with seventeen women participants who identified themselves as having received compassionate midwifery. Women’s rich accounts of their care were analysed using the principles of Interpretive Phenomenological Analysis (IPA).

Study Findings: Six major themes were identified. Women participants set their experiences of compassion from midwives within the context of their individual Need for Compassion, indicating that compassion was a response to their suffering during pregnancy, birth or the postnatal period. Women's need for compassion related to their anxiety, vulnerability, physical or emotional pain, problems, complications and the transition to motherhood. Women experienced compassion through a sense of the midwife really Being With them and this was something that women very quickly recognised in midwives. Compassion was also experienced through a sense of being in Relationship with the midwife and when midwives acted in ways that increased women’s feelings of Empowerment. Women identified midwives’ ability to provide compassionate care despite having to Balance conflicting demands, contradictions and paradoxes in their work. Compassionate midwifery Made a Difference to women by making them feel safer and more able to cope.

Conclusions: Compassionate midwifery was easily identified by women participants as an effective intervention for relieving their suffering and therefore must be acknowledged as an essential feature of maternity care. A dynamic model of Compassionate Midwifery in Balance is proposed based on the study findings, depicting the key features of compassionate midwifery. The findings provide a new and valuable resource on compassion in midwifery which is both research based and informed by women service users. This should now be utilised to inform practice, education and policy. Further research should explore the lived experience of
compassion for women from different cultures and those living in different circumstances. The Model of *Compassionate Midwifery in Balance* highlights the need to also consider midwives’ experiences of compassionate midwifery and future studies are needed to understand more about how midwives’ manage to balance and maintain compassionate care.
Acknowledgments

This thesis represents three years of my life and throughout that time it has been a joy and a privilege as well as a huge challenge. Many people have helped me in many different ways and I am extremely grateful for their support. I would like to thank my supervisors: Professor Jane Coad, Dr Elizabeth Bailey and Mrs Susan Lees. I think of them as my ‘compassionate midwives’ through the long gestation and birth of this thesis. Thanks also to Susan Dawson, Jane Dobson, Barbara Kuypers, Susan Law, Toni Martin, and Yvonne Thomas who all believed in me and encouraged me with this project. They have been important to my story because they listened to me when I first had this idea and that helped me move forward with it. I will be forever grateful for the women participants who gave their time so generously and shared their experiences of compassionate midwifery with me. Thank you to my daughters Sally and Lucie for putting up with my obsession and for all you have taught me about life. Extra special thanks to Lucie for the long hours she spent proof reading. Lastly I want to thank my wonderful husband Jem. It is hard to imagine how I would have done this without his love, generosity and wisdom.
‘Ask the woman, she will tell you everything you need to know’

Ina May Gaskin
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Note: Figures and Tables in this Thesis

All figures and tables are signposted within the thesis. Figures are situated within the body of the thesis text where appropriate and as space allows. Some tables are situated at the end of the chapter in which they are first introduced. Some figures and tables are produced on one whole page in landscape view to increase their size and aid clarity.
Chapter 1 Introduction

1.1 Purpose

This chapter sets the scene for the rest of the thesis and provides context by outlining the purpose and the rationale behind it. My own personal journey, which led to an interest in the subject area and influenced the direction of the research, will be described. Following this, brief summaries of each chapter provide an overview of the thesis structure in its entirety.

1.2 The Researcher in the Research

I was born in The Midlands in England in 1958. One of six children I grew up in a happy but busy home on a small council estate. My mother had four of her babies (including me) at home. She talked fondly of childbirth and of the midwives who supported her. Having lost my way rather at secondary school I fell in love and had my first daughter at seventeen; I had two by the time I was nineteen. I had my babies at the end of the 1970’s. Homebirth did not seem to be an option and I was, what I can only call, processed in the local obstetric unit. Both labours were artificially induced and I lay on my back in a very clinical room with an intravenous drip and monitors beeping. When I had my first daughter I had never been in hospital before and I was rather daunted by the environment and the regime. Yet I had a lovely midwife who was very gentle and caring. She made all the difference to what could have been a very scary experience and I never forgot her.

With two small daughters and lots of energy and ambition, I decided to train as a nurse. I had a happy and successful career in nursing before my move to midwifery in 2001. I had always had a keen interest in women’s health and particularly the interaction

---

1 This thesis is predominantly written in the academic style of third person. Exceptions to this are this section (1.2), Section 1.3 and Section 1.4 as well as entries from the researcher’s reflexive journal, all of which are written in the first person to aid the process of self-awareness and reflection.
between women’s position in society and how this impacts on their lives. Midwifery seemed like a natural career move. Once qualified I worked for less than a year on labour ward in an obstetric-led unit and then became a community midwife. I loved getting to know the women and supporting them through their childbirth journey. I was able to care for them in pregnancy and in the postnatal period, but usually, not during the birth. I was able to offer homebirths but the on-call system meant that I would not necessarily be able to support the women on my own caseload. I wanted to be on-call for all homebirths for women on my community caseload but I was told that this was not allowed. So I made the move to independent practice and this allowed me to work in the way that I thought would provide the best care to women and their families. I feel privileged to have been able to provide complete continuity by working in that way for nine years. However, regulatory changes around insurance for independent midwives made it very difficult to continue to work in this way and I returned to National Health Service (NHS) community midwifery. By this time I was also a Supervisor of Midwives (SOM) and in this role my passion focussed both on supporting women and supporting other midwives so that they could support women more effectively.

When I was asked, as SOM, to raise the profile of compassion within the maternity service where I worked, I did not envisage the direction it would lead nor the fascinating academic journey I was starting. The suggestion had come as a response to the launch and dissemination of ‘Compassion in Practice: Nursing, Midwifery and Care Staff - our Vision and Strategy’ (Cummings and Bennett 2012). It is possible that the messages it contained had taken a while to filter through to midwifery as it was 2014 when I was asked to ‘do something’ about compassion. I was given the impression that a modest piece of work would have sufficed, perhaps a poster for the notice board or a lunch-time seminar. These ideas seemed insufficient for what I had already identified as an important subject. I decided that it was not going to be another job to tick off. If I was going to do this I would first examine the subject in detail to fully appreciate how it applied to midwifery practice. It was not straightforward; compassion meant different things to different people. I tried an exercise in the Trust I worked in; I asked all the midwives to write down what they understood by compassion. Fifty-five people wrote down fifty-five different things.

I read profusely about compassion and became increasingly curious about it. It was ‘The Compassionate Mind’ by Paul Gilbert (2009) that had such a big influence on me because it sparked an interest in the science of compassion. Gilbert described how
Compassion is rooted in mammalian nurturing behaviour. I was reminded of the seminal work of Bowlby (1973), which led to the understanding that our brains are biologically designed to form attachments to others and respond to kindness and caring (Gilbert 2009).

Compassion is concerned with treating others with respect and kindness. I knew from my personal experience as a mother, grandmother and midwife, that this was a vital part of maternity care because women value it and respond to it. It makes a big difference to them. Crucially birth is not just about the creation of a new baby, it is about the creation of a new mother and this transition may have both joys and challenges. Supporting and enabling women to become confident mothers is at the heart of midwifery (Barker 2011:152). But I also knew compassion to be elusive, difficult to teach theoretically and variable from person to person.

As an independent midwife and a community midwife I had listened to lots of birth stories. Furthermore, as a SOM, I was a part of the Trust’s Birth Listening Service and had spent many hours listening to very sad, disappointed and sometimes traumatised women talk about their difficult or unsatisfactory birth experiences. During these sessions I had sometimes heard women say that their care lacked compassion. It seemed that compassion was recognisable in its absence. Yet there was little consensus about what compassion in relation to midwifery actually is, what it felt like, looked like, how, when and why it happened. While there were plenty of opinions, there was a lack of understanding. Lack of understanding regarding a phenomenon can be addressed through basic research (Jones 2014). To find out what the experience of compassion is like to the women who receive maternity services, I realised that I would need the structure and systematic process of a research study.

1.3 Theoretical Positioning

The overall aim of this study was to develop a deep understanding of the lived experience of compassionate midwifery to inform practice, education and service provision and guide future research in this area. The focus was on women’s experiences, thoughts and feelings and as the project lead and sole researcher my world view and approach facilitated and influenced this. Through an awareness of my own values and beliefs and extensive reading I started to identify that my epistemological position is interpretivist. Interpretivism is based on the work of Weber (1864-1920) who believed that the work of human science was to reach an
understanding rather than to explain or theorise (Chowdhury 2014). Interpretivism fits with a relativist ontology as it emphasises the importance of individual meanings, motives, goals and understandings to the perception of reality (Humphrey 2013). It sees knowledge as contextual and not absolute and so does not simply look at what occurred but how it occurred and in what context (Lin 1998). This fitted with my own experience of women during childbirth. All births are different and all women going through childbirth have very different understandings, ideas and expectations of it. Therefore, even for the same woman, the experience and significance of different births varies considerably.

My motivation for this thesis springs from a lifelong interest in women’s issues and recognition of the benefits that women’s health and wellbeing bring to society. I see the role of women as mothers as pivotal to the continuation and success of the human race. Yet some women have poor experiences of childbirth. Many women fear childbirth and see it as something to be endured rather than celebrated (Byrom and Downe 2015:191). As a feminist I am mindful of the controlling and sometimes disempowering influence associated with the historic medicalisation of childbirth (Beech 2011). Most births in the United Kingdom (UK) took place outside hospital until the 1960s and early 1970s when new technologies meant that women were required to go to hospital to be near the technology and the doctors who could use it. It bought advantages and disadvantages and analysis of these has been undertaken in feminist, midwifery and medical literature (Cahill 2001, Johansen, Keating and Fleming 2009, MacDonald 2011 Newburn and MacFarlane 2002). Although it is not within the scope of this study to explore all the implications of the medicalisation of childbirth in detail, it is considered further in Section 4.7. It is my belief that its effects are relevant to any study on care during childbirth. I recognise that the medical model of maternity care regards childbirth as a potential medical emergency rather a normal process, family event or rite of passage for the woman. Modern obstetric practice has undoubtedly brought benefits, in terms of care for women with serious pregnancy complications for example, but it has overlooked much of the social and psychological side of childbirth (Wagner 2001).

As a woman and as a midwife I have always been interested in discovering the best ways of supporting and empowering women as they become mothers. In order to do this, I believe it is vital to hear and understand their perspective. Men’s perspectives are also important to me. Most women are in relationships with men; loving fathers
(and loving female partners in same sex relationships) are really important and they also have contact with maternity services as they support their partners. Even if not as partners, most women have relationships with the key men in their lives: fathers, brothers, best friends and those relationships have a big impact on women and on their children. Research into men’s perspectives on compassion in midwifery is needed too, but that is for another study. Women conceive, grow, and birth their babies. I was clear about one thing: their perspective needed to be heard first.

1.4 Reflexivity and Insider Role

In this study I needed to be open and receptive to hearing women’s unique and personal experiences of the phenomenon of compassionate midwifery. However, I acknowledge my role as an insider with prior professional knowledge and personal motivations and that this influenced the research process (Asselin 2003, Moore 2012). Being an insider had benefits and disadvantages. As a midwife with many years’ experience I brought expertise in the field which was an advantage when gaining access to the study setting (Converse 2012, Toffoli and Rudge 2006). When seeking rapport, dealing with sensitive issues and using empathic listening skills to draw out women’s narratives I believe that my skills and experience were invaluable. Knowledge of the maternity services also helped me to understand how details within their stories might relate to the birth process and the technical, cultural and organisational aspects of care. In this way discernment, understanding and interpretation were enhanced. While ‘understanding is deeply informed by experience’ (Smythe 2011) I was mindful that I cannot free myself of my background which may hold prejudices, assumptions and bias (Godamer 2004: 280). Therefore I tried to be alert to how this has potential to influence the study and be constantly open to hearing and discovering new understandings (Smythe 2011). Lykkeslet and Gjengedal (2007) warn of the need to preserve some degree of analytical distance but how this can be achieved is not clear. However, Gilgun (2015) describes reflexivity as a way forward through awareness of the multiple influences the researcher has on research and vice versa. She identifies three key areas for reflexivity: the topic chosen, the perspectives of the people involved and the audience for whom the research findings are intended. With this in mind I engaged in a process of reflexive analysis and ‘methodological self-consciousness’ (Finlay 2002) to try to recognise and balance insider/outsider perspectives (Burns et al 2012). To aid this process I used a reflexivity journal to facilitate awareness of issues around positionality or role conflict. Journals or diaries provide a way of reflecting on
the research process by recognising, exploring and working through problems in meaningful ways (Clancy 2013). This journal became part of the study data from the very beginning and excerpts from it are included in this thesis, predominantly in Section 5.5.4.

My genuine curiosity coupled with my determination to understand more about compassion provided a good basis for the research process. My passion for midwifery and a professional interest in how practice impacts on the experience of women, babies and their families ensured I had the motivation to carry it through. The skills, knowledge and experience I had gained in practice, outlined in Section 1.2, assisted me when recruiting and interviewing. This background assisted with access to study sites and participants because maternity service managers had confidence in me to be able to undertake the study sensitively and appropriately. I also had some insight into how my position as ‘insider’ could potentially be problematic as it might influence aspects of the study; for example it could influence the way that participants relate to me and interact with me. Willingness to engage in reflexivity and in techniques to minimise bias balanced this. By having an awareness of the significance of my professional role on my researcher role I attempted to utilise the benefits and minimise the disadvantages. Thus my positionality proved to be advantageous in the research area, sustaining me during the research process, and a befitting one from which to undertake research into compassion in midwifery.

1.5 Structure of the Thesis

Chapter 2 This chapter sets the background for this thesis. Becoming familiar with a problem or phenomenon by finding, evaluating and understanding the related literature is an important phase in research as it assists in defining the research question, aims and objectives (Haynes 2006). The process provided a depth and breadth of understanding around the topic and prompted deep thinking and reflection. It deals with the social, political and professional reasons why compassion has become an important yet sometimes controversial topic in healthcare and how this has impacted on midwifery. What is already known about compassion in healthcare (in general) is reviewed and then, more specifically, compassion in nursing and midwifery is considered.

Chapter 3 This chapter explores the concept of compassionate midwifery. In the absence of any empirical research or analysis concerned with the nature of
compassion in relation to midwifery practice, a concept analysis was undertaken. A process of concept analysis is used to thoroughly explore the features of compassionate midwifery found in the literature and elsewhere. This concept analysis presents the theoretical starting point from which to plan the empirical research study. However, it does not inform the empirical study. It is not returned to until the study findings are discussed.

Chapter 4 This chapter presents the study’s methodology and starts by identifying the aims and objectives of the study. The importance of methodological fit is debated and the methodological design is developed in light of this. The chapter concludes with the methodological model for the study.

Chapter 5 This chapter presents and justifies the study’s methods. The study setting, recruitment strategy and ethical considerations will be presented. Data collection and analysis methods will be described in detail. Reflexivity will be discussed and illustrated through entries from the reflexivity journal. This chapter will also consider ways of ensuring quality within the study.

Chapter 6 This chapter presents the findings. The study findings, arrived at through the process of data analysis are presented in this chapter. Each of the themes identified during the analysis are presented. Women participant’s words are used to support the researcher’s interpretations

Chapter 7 In this chapter the study findings are critically considered and interpreted against the aims of the study and what is already known. It starts with re-visiting the concept analysis in Chapter 3 for the first time since the study commenced. The concept analysis and the study findings are compared and contrasted in terms of their methodological contributions and the contribution they have made to furthering knowledge on compassionate midwifery. The significance of the themes which make up the findings are critically debated and limitations of the study identified. A new model of women’s experience of compassionate midwifery, developed from this study’s findings is proposed.

Chapter 8 This chapter draws together the key implications of the study findings for midwifery practice, education and policy.
Chapter 9 This chapter makes recommendations for further research: As the first empirical study on compassionate midwifery, this study has prompted many more questions around this subject and these are discussed in this chapter.

Chapter 10 This chapter concludes the thesis by summarising its most important findings and how these have met the study aims by increasing understanding of women’s experience of compassionate midwifery. Ways in which this increased understanding should impact of the direction of midwifery care are proposed.

1.6 Summary of Introduction

This chapter has set out the position of the researcher within the research and as such it provides important context for this thesis. The context has offered the reader an insight into the researcher as a person and the events that drove and directed the research. The researcher’s theoretical positioning and awareness around her role in the research has been examined and researcher reflexivity has been proposed as an important tool for navigating the insider-researcher role. Finally, each chapter of the thesis has been outlined. Collectively, these chapters form a thesis which represents a novel and valuable study of a formerly little understood phenomenon: compassionate midwifery.
Chapter 2 Why is Compassion in the Spotlight in Healthcare?

2.1 Introduction

This research project was undertaken because of the researcher’s drive to close the gap in knowledge and understanding around the nature of compassion as a part of midwifery care. To address this gap, the aim was to increase understanding of compassionate midwifery as a concept and as an experience. This is important as it contributes to the body of knowledge on midwifery care and has the potential to improve the care and experiences of women using maternity services in the future. Before this could start a number of questions needed to be explored and addressed with reference to the literature. Clinical experience, discussion with colleagues, and professional reflection assisted in formulating some key questions:

- Why is compassion in the spotlight in healthcare?
- What is already known about compassion in healthcare?
- What is compassionate midwifery?
- How does this impact on practice?

Time spent on these points provided the necessary background and insight on which to launch the research. It also emphasised the need for this research and the contribution it could make to the body of knowledge that is midwifery.

Compassion has become a familiar topic in healthcare but it has not always been that way. Few medical, nursing and midwifery texts or journal papers before 2010 include compassion as a part of clinical caring and it was mainly confined to occasional articles that dealt with the ‘spiritual side’ of care (Goldberg 1998). Yet it has become part of the everyday language of contemporary healthcare. This chapter seeks to try to explain the background to this by examining how increased focus on quality of care and a few high profile failures of care have influenced this development. In particular it will explore how the rhetoric within a report on The Mid Staffordshire Inquiry (Francis 2013a) had a profound influence on the NHS in the UK and placed compassion central to quality care. The responses from the UK Government and the professions will be discussed as well as the significance of the organisational culture in the NHS in order to present some of the background and issues that underpin compassion in healthcare.
2.2 Failings in Healthcare

The UK is not alone in experiencing major failings in healthcare provision. Many other parts of the developed, post-industrial world have experienced similar problems (Walshe and Shortell 2004). Whilst the focus of concern in the UK has been NHS failings in care, private healthcare has not escaped. The most notable example being the case of Winterbourne View, a private hospital for people with learning disabilities, which was exposed for its poor and inappropriate care practices some of which constituted criminal abuse (DoH 2012).

For over a decade there has been increased concern over the safety, quality and experience of healthcare in the UK (Keogh 2013, National Advisory Group for Clinical Audit and Enquiries 2013). This has been set against a background of rising demands including an aging society, increases in long term conditions and rising expectations (NHS England 2013). The influence of a market driven healthcare system and the concept of patients as healthcare consumers led to more public scrutiny of care and more emphasis on how people are treated when they need healthcare (Dixon et al 2010). In response to this The Point of Care (Goodrich and Cornwell 2008) programme for The King’s Fund included research and recommendations aimed at improving the experience of care. Their work demonstrated the value of seeing the ‘person in the patient’ and stressed the importance of treating people with kindness and compassion. It was a real attempt to gain insight into the meaning of person-centred care and understand how that translated in clinical care settings. While Goodrich and Cornwell (2008) used the words kindness and compassion in relation to healthcare it was not to be them who would be remembered for it. Arguably, although their work was highly acclaimed (Allan 2009) they were unable to elevate this important concept into the forefront of healthcare strategy. However, what facilitated that were high profile cases demonstrating serious failures in care and in particular those at Mid Staffordshire NHS Trust.

2.3 The impact of the Report on Mid Staffordshire NHS Trust

The investigation into the failings at Mid Staffordshire NHS Trust not only shocked the nation, it highlighted the need to see compassion as key to quality care. The investigations conducted by Robert Francis QC related to care provided between 2005-2009. The first was an independent inquiry which dealt predominantly with the quality of care at Stafford Hospital (Francis 2010) and the second, a public inquiry which
considered the organisational failures and governance (Francis 2013a). Francis (2013a) considered evidence from over 250 witnesses and over a million pages of documentary evidence. After the first report the press, public and the Government were all aware of the serious nature of the concerns. Francis detailed the appalling suffering, negative culture, tolerance of poor standards and the systemic failure to protect patients from unacceptable and inhumane treatment. The second report listed 290 recommendations which spanned many aspects of care from standards of behaviour to organisational culture. Notably, the words compassion or compassionate were used 16 times in the executive summary and 53 times in the rest of the full report. Compassion had been used in relation to healthcare before but it had never been heard like this.

2.4 Government response

The Government response to the long awaited final report on Mid Staffordshire NHS Trust was outlined in Patients First and Foremost (DoH 2013), a document criticised for being ‘muddled and piecemeal’ by some (Royal College of Midwives (RCM) 2013). Its failure to address all of Francis’s 290 recommendations was seen as a missed opportunity (Hall 2013a) but it set out an important shift in position, that of making quality of care as important as quality of treatment. The document states the importance of ensuring that ‘compassion is central to the care’. While stopping short of explaining what compassion is, it made clear links to humanity, kindness and respectful care (DoH 2013). It also put forward plans for changes to inspections, reporting systems, whistleblowing and professional training, education and regulation. There was a particular emphasis on the need for nurses to spend at least a year as a health care assistant (HCA) prior to starting a nursing degree programme. The implication being that basing nurse education in universities and creating an all-graduate profession has contributed to a workforce who are highly educated but unable to provide hands on care with compassion (Scott 2004). An early review of six pilot schemes (which included some students wishing to go on to midwifery degrees) has indicated that this system may have a number of benefits (Enterprise Innovation Partnership 2016) although longitudinal research is needed to ascertain the ongoing effect on students as they progress through their degree programmes and on to employment. Concerns regarding this scheme include the lack of any credible link with increasing compassion in nurses (Keogh 2014) and serious doubts about its funding and supervision which could lead to prospective student nurses and midwives learning bad habits which will
need to be unlearnt, rather than learning about compassionate care (Hall 2013a).
Moreover an opportunity to find robust mechanisms for building compassion into pre-
registration nursing courses was largely missed. This suggests that compassion is
viewed as something that does not need to be studied, taught and assessed like
clinical skills or theories but is a feature of unqualified HCPs work.

2.5 Professional response

The medical profession’s response to Mid Staffordshire appeared to have side-stepped
compassion in the main. The General Medical Council (GMC) concentrated on medical
training and professional regulation but stopped short of any measures to address lack
of compassion in healthcare (2013). The British Medical Association (BMA) avoided
compassion too and focussed on staffing levels, duty of candour and leadership in their
response (BMA 2015). However, individual doctors have acknowledged compassion as
an important but often neglected side of medical care (Haq 2014, Haslam 2014).
Arguably the medical profession failed to embrace compassion as something that was
relevant to them following the Francis Report (2013a). The General Medical Council’s
(GMC) response to Francis outlined 24 areas for action, yet none of these addressed,
or mentioned compassion (GMC 2013). Given Francis’s focus on lack of compassion
this seems puzzling. Cherry et al (2014) wonder if the profession’s history of male-
dominated, scientific rationality makes doctors prone to intellectualise emotions in order
to remain objective in their work. They suggest that there could be a professionally
ingrained blind spot regarding the emotional content of compassion. Added to which
there is evidence that some doctors seek to disengage emotionally due to fear of
compassion fatigue and burnout (Hamilton, Tran and Jamieson 2016, Najjar et al
2009), a psychological defence mechanism that is experienced by healthcare workers
in stressful work environments (Youngson 2012:14).

Although the medical profession may not have identified with compassion, the nursing
profession did. A clear response to the events at Mid Staffordshire came from the
Chief Nurse well before the final report. Following a consultation exercise the
introduction of a vision and strategy for nursing, midwifery and care staff was launched
(Cummings and Bennett 2012) in the wake of public concern about the events that
were unfolding in the press (Cook 2009). A key aspect of this strategy was a
framework for quality healthcare practice and because it contained six concepts: care,
competence, communication, courage, commitment and compassion it was known as
the 6 Cs. There is a clear emphasis on compassion as the strategy is entitled ‘Compassion in Practice’. In terms of an explanation about what compassion means the chief nurse stated that it could be described as ‘Intelligent Kindness’.

The 6 Cs framework has much in common with the NHS constitution which Francis (2013a) recommended should set out the values, rights, obligations and expectations for patients, public and staff (DoH and Public Health England 2015). Interestingly, Cummings and Bennett’s framework was not an entirely new idea. In fact their 6 C’s were similar to Roaches theoretical model of care (Bradshaw 2016, Roache 1992) which also used 6 Cs. In Roache’s (1992) model compassion is seen as a moral attribute and something that comes from within while in Cummings and Bennett’s 6 C’s the implication is that compassion relates to outward behaviours and must be exhibited in order to meet role requirements and outcomes. For this reason Bradshaw (2016) calls this the commodification of moral virtues and draws attention to the negative effects of attempting to externally enforce these behaviours. Furthermore Cummings and Bennett not only omitted to reference Roache’s (1992) work but failed to provide any rationale, theoretical underpinnings or evidence of their impact on care outcomes (Baillie 2015).

It has been claimed that none of the major professions emerged with any credit from The Mid Staffordshire inquiry (While 2015). Midwifery was not singled out in the Mid Staffordshire Inquiry nor was it addressed in Patients First and Foremost (DoH 2013). Any mention of midwife/s or midwifery is predominantly in relation to the Nursing and Midwifery Council (NMC) organisation and regulation because Midwifery is frequently included in the same sentence as nursing. The phrase ‘Nursing and Midwifery’ was presented as inseparable under the umbrella of The Mid Staffordshire report (Hall 2013b). It is a term which emphasises the close link these two professions have and the regulatory body they share. However, it could be argued that the term serves to ensure that the smaller profession of midwifery is not left out and yet not really acknowledged. This meant that in terms of the response to Mid Staffordshire, midwifery was added onto everything that applied to nursing and the two professions were treated as one. With the notable exception of Hall (2013a and 2013b) there has been little exploration of the real implications for midwifery. This issue is central to the background for this thesis.
Compassion in Practice (Cummings and Bennett 2012) had a clear nursing focus but it offered some guidance for midwifery in a single infographic entitled: Vision and Strategy: an approach for midwifery care (GOVUK 2013). Much of this was concerned with a broader health improvement strategy and the ‘midwifery service offer’. In terms of compassion in midwifery it describes this approach as:

‘Providing holistic, responsive and compassionate care. Developing unique, supportive relationships with women, their partners and families with an emphasis on respect, dignity and kindness’

It would be difficult to disagree with these ideals, yet it is not clear exactly what is meant by compassionate care and no explanation is given. Therefore it is not clear what would be lacking if the word were omitted from the statement or replaced by another. What remains nebulous is what a midwife would do and say, how she would behave if she were providing compassionate care. Without insight into this there might be as many different ideas about it as there are midwives. This is a clear barrier to teaching, assessing, supporting and sustaining compassionate midwifery and a serious flaw in the strategy to provide women and babies with compassionate midwifery care. Nevertheless, the report on The National Maternity Review: Better Births is clear that women want, and should receive, safe, personalised compassionate maternity care (NHS England 2016). The report particularly emphasised the need for compassionate care ‘when things go wrong’. The midwifery profession needs a credible definition of compassion which is supported by research if it is serious about ensuring midwifery is compassionate.

2.6 Compassion and the organisational culture of healthcare

Compassion in Practice (Cummings and Bennett 2012) presented the ‘6 Cs’ as a way of changing the culture of healthcare by situating the problem with the individual healthcare worker (Crawford et al 2014) and directing them to adopt and demonstrate the 6 Cs’ ethical and behavioural values. This suggests that the nursing establishment placed the blame for poor, uncompassionate care on individual ‘bad apple’ clinicians rather than on the multifaceted causes of harm within complex healthcare systems (Martin and Dixon-Woods 2014). Efforts to improve compassion in healthcare delivery through the 6 Cs has been criticised for being reductionist when what was required was
a whole system approach to model compassion throughout an organisation, led by senior management (Dewar and Christley 2013).

Considerable analysis has taken place regarding whether compassion is an innate quality (Baverstock and Finlay 2015), something that can be learnt and developed (Rolfe and Gardner 2014, Youngson 2012), or contextual (Paley 2014 and 2015). There have been convincing arguments on all sides. But it seems unlikely that compassion can be imposed (Wang 2016). Newdick and Danbury (2015) also make the distinction between trying to solve the problem by managing individuals or by managing the systemic influences which shape an individuals behaviour. They point out that despite an array of carefully worded professional codes of conduct for healthcare professionals and NHS managers, these were unable to prevent the poor care standards tolerated at Mid Staffordshire NHS Trust. Similarly, a plethora of reporting systems, risk management processes and clinical audits did little to capture the reality of what was happening to patients or to escalate warning signs into action (Rafferty et al 2015). On the contrary, there seems to be an argument for considering these very reporting systems part of the problem as managers and professionals spend more and more time concentrating on them. Crawford et al (2014) have highlighted the threatening culture of production-line, target driven healthcare in which compassion is inhibited. Francis clearly found this at Mid Staffordshire where he recognised a culture of ‘doing the system’s business and not that of the patients’ (Francis 2013b).

There are also tensions which prevent clinicians having the courage to report or escalate concerns about poor care, the key ones being fear, bullying and resignation that nothing will be done (Dewar and Christley 2013, Griffith 2013, Patrick 2012). As one doctor commented:

“You cannot feel peoples pain, you cannot continue to want to do the best you possibly can when the system says no to you…..” (Francis 2010 1st inquiry)

In recognition of the place that organisational factors play in leading, supporting and sustaining compassion, an organisational barometer has been developed to assess the culture of care across a healthcare organisation (Rafferty et al 2015). This may be a useful adjunct to patient surveys and other feedback tools like The Friends and Family Test and it may provide a screening tool for organisational dysfunction. However, it provides no mechanism for dealing with problems highlighted in The Francis Report (2013a).
2.7 The Kirkup Report

An investigation into serious failings in maternity care, including neonatal and maternal deaths, at Morecambe Bay NHS Trust (Kirkup 2015) focussed on deficits in clinical competence and the breakdown of interdisciplinary relationships. Dr Bill Kirkup led the investigation which will be remembered for its disturbing revelations of the dysfunctional culture within maternity services at the Trust. However, there was no mention of compassion throughout the report. Arguably it was not relevant to the circumstances. However, it is possible that the different professional expectations placed on nurses and midwives influenced this. The Francis Report (2013a) and the Kirkup Report (2015) both highlighted problematic organisational cultures. However, Francis was primarily critical about the nursing care of ill or frail patients and therefore a focus on compassion was perhaps due to compassion being an expected trait of nurses. In contrast, The Kirkup Report (2015) implicated midwives, obstetricians and paediatricians providing maternity services as well as their management and regulatory systems. Midwives were particularly criticised for their interpretation of their role and role boundaries and failing to take appropriate action. This may say a lot about the culture of maternity care and its relationship to obstetrics which is discussed further in Section 3.3.3. However, it is clear to anyone reading The Kirkup Report (2015) that opportunities for compassion existed. Maternal and neonatal deaths for which families did not receive proper explanations, a bullying work culture and management cover-ups were all exposed and painted a picture of a service that was in distress. There may be good reasons why compassion (as an aspect of quality care) was not considered when investigating the poor quality care identified by Kirkup (2015). It is possible that because The Kirkup Report (2015) was about maternity services the emphasis was on risk, roles and competence; arguably, there were no expectations of compassion.

2.8 Conclusion

The report on the Mid-Staffordshire Inquiry heralded the widespread use of the word compassion in relation to healthcare. Coming at a time when concerns about quality and safety of care had been mounting, Francis (2013a) presumably felt that the word encapsulated what was missing in the numerous accounts of poor care within the organisation. It has proved to be an emotive word, eliciting a range of responses from different stakeholders. One of the key divergences being whether compassion emerges from the organisation or from the individual. While the idea of compassion
has resonated with many in the nursing profession, others have argued that the word is just crowd-pleasing stuff (Middleton 2014). Cummings and Bennett (2012) in response to Mid-Staffordshire have been the catalysts for emphasising compassion in relation to nursing and midwifery through the Six Cs and there have been considerable efforts to examine how this relates to nursing. Nursing and midwifery are not the same yet because they share a regulatory body they are frequently treated as such. Therefore there still remains a need to define compassion in relation to midwifery and consider its relevance. However, to find out whether compassion is an identifiable, vital aspect of midwifery care which makes a difference to women, or whether it is just fashionable rhetoric without real substance, will require research. But the question remains, what is compassionate midwifery? In order try to answer this question, the actual concept of compassionate midwifery needed robust exploration and analysis. This was achieved by undertaking the concept analysis presented in Chapter 3
Chapter 3  A Concept Analysis of Compassionate Midwifery

3.1 Background

Compassion in healthcare emerged as both a core value and a key concern following the enquiry into Mid Staffordshire NHS Trust (Kneafsey et al 2015, McCaffrey and McConnell 2015). Consequently the word ‘compassion’ became visible in many aspects of nursing and midwifery and was incorporated into strategy, policy, recruitment and pre-registration education (Fry et al 2013, McClean 2012, Waugh et al 2014). The Nursing and Midwifery Council (NMC) incorporated compassion into professional standards for both nurses and midwives (NMC 2012, NMC 2015). However, both the NMC and the Department of Health (DoH) have an umbrella approach to nursing and midwifery and this means that nursing, as the larger and dominant culture, has prevailed and that midwifery has not always found a voice with which to express the fundamental differences between the professions (Summers 1998 and Taylor 2004). Arguably, whilst nursing has aligned itself with compassion, midwifery practice has failed to explore or analyse compassion in relation to care around childbirth.

Nursing has always had a strong association with compassionate ideals, for example Florence Nightingale as the ministering angel to the sick ( Straughair 2012a). This may go some way to explaining why as a profession nursing has undergone considerable exploration and analysis of compassion (Davison and Williams 2009, Schantz 2007, Schofield 2012, Straughair 2012b Von Dietze and Orb 2000). There have also been a number of research studies exploring compassion in the context of acute care for older people (Dewar and Nolan 2013, Perry 2009) and on general hospital wards (Bramley and Matiti 2014, Curtis 2015). Dewar and Nolan’s (2013) research with older people found that relational practices were important including getting to know the person and what matters to them. The ability to create caring conversations with patients and their families was key. Perry (2009), Bramley and Matiti (2014) and Curtis (2015) all found compassion in nursing settings to be associated with the little things that convey caring

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2 This concept analysis of compassionate midwifery was adapted for publication in The Journal of Advanced Nursing and is reproduced with permission in Appendix 12.9.

and compassion or what Perry (2009) calls ‘paying attention to the essential ordinary’. This requires nurses to know the patients they look after so that they can provide personalised care. While all of these studies talked about compassionate care taking time, Curtis (2015) noted that small acts could be quite fleeting and yet still convey compassion.

Compassion in midwifery has yet to be explored as a concept. Midwives support predominantly young, healthy women who are going through a normal physiological process which is also a life-changing event and rite of passage. Midwifery and nursing share much in common and compassion in midwifery may have similarities to compassion in nursing. However, they are different enough to consider the possibility that the concept of compassion might have a significantly different relationship with midwifery.

Compassion in midwifery is a relatively new concept. Despite the assumption that compassion is a fundamental concept in healthcare (Chambers and Ryder 2011) it has been largely absent from midwifery literature, textbooks and professional guidance prior to 2012. As the 6 Cs (Cummings and Bennett 2012) filtered through to midwifery there was little analysis; rather it became something of a ‘buzz word’. However, this can be set in context by looking back over the last thirty years of maternity care. Some of the key events, documents and policies which have influenced different care concepts in midwifery are shown in Table 3-3, starting with the launch of the Midwives’ Information and Resource Service (MIDIRS) which used information and research as a means of improving midwifery care, developing the midwifery profession and effectively initiating evidence-based care. While the list is not exhaustive it demonstrates that different focuses emerge for different reasons at different times, despite all of them being important and relevant. It is useful to consider compassionate midwifery in this way as it places it within a politically and professionally influenced time-line in which a range of different (yet related) care concepts have been put forward as midwifery’s modus operandi.

The updated Midwives Rules and Standards (NMC 2012:15) which came into force in 2013 included the word ‘compassionate’:

“You must make sure the needs of the woman and her baby are the primary focus of your practice and you should work in partnership with the woman and her family, providing safe, responsive, compassionate
care in an appropriate environment to facilitate her physical and emotional care throughout childbirth’.

*The Midwives Rules and Standards (NMC 2012:15)*

These rules directed midwives to practise compassionately. However, The Midwives’ Rules were revoked in 2017 in conjunction with the end of statutory supervision of midwives. In their absence it is The Code (NMC 2015) that sets the standards for practice for both nurses and midwives. It also highlights compassion as necessary to good care:

‘1. Treat people as individuals and uphold their dignity.

To achieve this you must:

1.1 Treat people with kindness, respect and compassion

*The Code (NMC 2015)*’

However, if midwives are to do this they will need to have a clear understanding of what compassion means when applied to midwifery and how it might differ from kindness or respect. To this end an analysis of the concept of compassionate midwifery was undertaken by the researcher with the supervisory team and is published in a peer reviewed journal (Ménage et al 2017). This publication is reproduced with permission in Appendix 12.9. A comprehensive concept analysis was also a valuable adjunct to empirical research. The first step involved exploring what a concept is and the purpose of analysis. An adaptation of Rodger’s model (2000a) provided the methodological framework for conducting the concept analysis of compassionate midwifery.

For ease of reading the word ‘woman’ or ‘women’ will be used to refer to woman or women during the pregnancy, birth or the postnatal period.

### 3.2 What is a Concept?

A concept is not defined by the word or words it uses, it is the idea or characteristics behind the words that reveal a concept (Rodgers 2000b). Watson (1979) described a concept as ‘a mental picture or image’ which ‘symbolises ideas and expresses an abstraction’. Philosophical debate has been extensive but can be broadly divided into two opposing views in which concepts are seen either as fixed, definite entities or truths (entity theory), or as habits or capacities for certain behaviours based on commonalities in use of the words (dispositional theory) (Rodgers 2000b). One of the
clearest distinctions is whether or not a concept is fixed with defined boundaries or is unfixed and evolving. The fixed entity view is problematic when exploring most concepts and it seems more likely that concepts are predominantly dispositional (Rodgers 2000b), and not based on absolute criteria but rather based on ‘similarities’ and what Wittgenstein called ‘family resemblances’ (Biletzki and Matar 2014).

Moreover a concept is dynamic in that it may develop and change over time and in different contexts.

The concept of compassionate midwifery is as yet immature and evolving and has only recently started to appear in professional language and the literature. The assumption that compassionate midwifery is universally understood and used could cause confusion and thus impact on practice. Clarification of the evolving concept contributes to improved understanding within the profession and provides a more robust basis for practice and for further empirical research.

3.3 Concept Analysis

The word ‘compassion’ has become part of the language of maternity care (in line with the rest of UK NHS healthcare) and yet little is known about what compassion means to maternity service users or professionals. In such circumstances a concept analysis can be used to characterise a situation relating to practice or research (Walker and Avant (2005:64-65). Furthermore, Westra and Rodgers (1991) have described how they used concept analysis to examine the usefulness of a concept, previously used in one discipline, in a different discipline.

The purpose of a concept analysis is to identify consensus regarding that concept by understanding its use and also to establish the state of the art and science (Rodgers 2000a, Hupcey and Penrod 2005) and to ascertain the level of maturity of the concept (Morse 2000). A number of models have been widely used, although some, like Walker and Avant’s (2005:65) has been criticised for reflecting a fixed idea of what a concept is and is not (Rodgers 2000a, Chinn and Kramer 2011). When dealing with an evolving concept an evolutionary approach is appropriate. Based on a cyclical approach, it reflects inductive discovery and acknowledges that concepts can change and develop in different ways over time (Rodgers 2000a). To this end Roger’s evolutionary model of concept analysis was used with some adaptations.
This model was selected as it utilises Rodger’s (2000a) robust methodological procedure in a clear and more concise six step plan. The main adaptation was that rather than presenting an exemplar or model case of the concept, the findings are depicted in a schematic representation or model. The six-step process is shown below in Table 3-1.

**Table 3-1 Model of Concept Analysis adapted from Rodgers (2000a)**

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<tr>
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<th>1. Identify and name the concept of interest</th>
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<td>2. Collect data</td>
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<td></td>
<td>3. Identify surrogate terms and relevant uses of the word</td>
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<td></td>
<td>4. Identify the references, attributes, antecedents, consequences of the concept</td>
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<td></td>
<td>5. Identify related concepts</td>
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<td></td>
<td>6. Develop a schematic representation or model of the concept</td>
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The six steps imply a systematic process, however it was not linear with one step leading to the next. In reality the process was much messier. In common with Lackey’s (2000) observations, at times the individual steps of concept analysis merged together as some features of the concept remained resistant to classification or clarification. The process was iterative and went back-and-forth through steps one to five as individual steps required revisiting frequently. This allowed data to be considered and re-considered as understanding developed.

3.3.1 **Identify and name the concept of interest**

The concept of compassionate midwifery is created using the adjective ‘compassionate’ to describe a type of or aspect of midwifery practice. This analysis will first break down ‘compassionate midwifery’ into its constituent parts: ‘compassion/ate’ and ‘midwife/ry’ so that these two entities can be fully understood before examining
their relationship to each other and exploring the meaning, value and maturity of the concept.

3.3.2 Compassion

Compassion is a quality sometimes associated with being morally right, worthy and in the best interests of the community. In this way it involves making moral judgements to reduce suffering, protect the vulnerable and help those in need (Smith 2009). This view sees compassion as a moral choice or virtue (Von Dietze and Orb 2000). While some see this as an essential feature of caring (Saunders 2015), others note that the moral position does not always lead to compassion. Gilbert (2015) points out that a moral position often supports ingrained ideas regarding right and wrong which may be related to kinship or alliances with particular groups. It could be argued that this is a form of tribalism and it can lead to judgements about who does (or does not) deserve compassion.

The anthropological/evolutionary viewpoint sees compassion as a distinct affective state and emotional adaptation which has evolved as part of survival and reproduction related situations. Related to mammalian nurturing behaviour, compassion is a prosocial behaviour which helps with mate selection and forming co-operative alliances with kin and non-kin, thus strengthening communities (Gilbert 2014). Thought to be a primate adaptation, compassion-like behaviour towards the vulnerable or wounded has been observed in the primates most closely related to humans (Warneken and Tomasello 2006). However, it is highly adapted and refined in humans. From this perspective humans are seen as genetically 'programmed' to act compassionately. Alongside this humans also have a system to deal with survival which is alert to threats against the person or their loved ones. Gilbert (2009:123-147) explains how this threat system can activate powerful emotions including fear, sadness, despair, frustration, rage and even violence. Importantly when the self-protection system is activated compassion becomes much less accessible. Human beings appear to have evolved with these primitive functions which, even today, remain ‘both the best and worst in us’ (Gilbert 2015).

It seems that compassion is controversial because it has been the source of debate and deliberation amongst scholars from many disciplines including philosophers, spiritual leaders, religious scholars, psychologists, neuroscientists, anthropologists and those concerned with moral and ethical studies (Goetz, Keltner and Simon-Thomas...
Not surprisingly there are numerous definitions which demonstrate slightly different perspectives, but key themes include recognition of and response to another’s suffering. Perhaps one of the most confusing aspects of compassion is its relatedness to other emotions like empathy, sympathy and pity. Goetz Keltner and Simon-Thomas (2010) claim that while compassion can be seen as a distinct entity, it is part of a family of emotions which includes pity, sympathy and empathy. This was evident in a search for different definitions (see Table 3-4). Many definitions use other terms within the family of compassion related emotions, either alone or in combinations to define compassion. This demands some understanding of the subtle differences associated with the different members of the compassion family and also with related concepts like kindness and altruism. These are summarised in Table 3-5.

The word *sympathy* comes from the Greek *syn* (meaning together) and *pathos* (meaning feeling) (Online Etymology Dictionary 2015). It is the ability to feel with another person when they have a misfortune. Thus it reflects an emotional connection at a human level. In contrast, *empathy* is the ability to understand the feelings of another, to be able to put oneself in another’s shoes and see the world as the other sees it. Importantly empathy has therapeutic implications and is a mainstay of counselling and clinical psychotherapeutic theory (Cutcliffe and Cassedy 1999, Elliott et al 2011). Although often used instead of the word compassion, it does not necessarily demand a feeling of connection on an emotional level (although it may be present) but rather a theoretical understanding. At a neurological level this ability to understand the experience of others is thought to involve mirror neurons which may initiate a mirroring effect in those observing suffering, affecting their facial expression and body posture (Carr et al 2003). However the nature of the link between mirror neurons and empathy remains unclear.

To *pity* is to feel sorrow for the misfortunes of another and it differs to compassion in that it fails to connect to the other-as-person (Von Trevenar 2001). Pity does not benefit the other person as in itself it does not incorporate sympathetic or empathic concern, understanding or connection. Moreover, pity can cause feelings of inadequacy and shame in the person who is pitied (Von Trevenar 2001). To pity another is an expression of inequality where the person being pitied is seen as inferior or at a disadvantage. Compassion focuses on the person-as-other and an equal relationship and it incorporates sympathy (emotional connection) and empathy (seeking to gain understanding) and also the motivation to help alleviate suffering which leads to
compassionate behaviour. In this way compassion has emotional, cognitive and behaviour aspects. Whatever it is that fuels the motivation to act compassionately is likely to be the essence of compassion but it is also the subject of some debate. There are two convincing perspectives: the moral/spiritual perspective and the anthropological/evolutionary perspective.

Definitions of compassion vary but most depict compassion as a set of inter-related elements and incorporate thoughts, feelings, motivation and action. To represent this, a simple model was synthesised by the researcher, which organises the widely-held view that compassion is not just a moral position or trait but a process that links emotions, motivations and behaviours (Clift and Steele 2015, Greenberg and Turksma 2015, Halifax 2012, Jazaieri et al. 2014, Kneafsey et al. 2015). This is shown in Figure 3-1. In this four part process recognition of another’s suffering is followed by an emotional response or connection with the sufferer. This leads to the motivation to try to alleviate the other’s suffering and then the actions or behaviour aimed at alleviating it.

**Figure 3-1 Model of the Process of Compassion**

![](image.png)

3.3.3 **Midwifery**

The concepts of midwife and midwifery are well-defined and are words that are institutionalised in UK culture and in many other countries of the world. The word midwife means ‘with woman’ and is probably one of the most ancient of roles in human civilization as women have sought an experienced, kind and wise companion to care for them during childbirth. The professional status of midwifery in the England and Wales commenced with the 1902 Midwives Act when formal, supervised training and registration became mandatory and the first Scottish Midwives Act followed in 1916 (Leap and Hunter 1993:98). Today midwives in the UK are practitioners in their own right and are seen as experts in normal pregnancy and birth. This is not the case in all
countries and the exact role and responsibilities differ throughout the world. The International Confederation of Midwives (ICM) definition of the midwife (ICM 2017) is the basis of all other definitions (Appendix 12.1). Key midwifery concepts that define the unique role of midwives includes:

- Partnership with women
- Respect for human dignity
- Advocacy for women so that their voices are heard
- Cultural sensitivity
- Focus on health promotion
- Viewing pregnancy as a normal life event

There were approximately 25,600 whole time equivalent midwifery posts in the UK in 2016 (RCM 2016). With many working part-time, the number of actual midwives is considerably more and information released by the NMC suggests the number is in excess of 41,000 (What Do They Know 2013). Midwives’ practice is subject to statutory regulation by the NMC.

Since the early 1960s midwifery has moved from being community-based to a predominantly hospital-based profession. The Peel Report (Standing Maternity and Midwifery Advisory Committee 1970) which called for all babies in Britain to be born in hospital was the catalyst for the medicalisation of childbirth under the dominance of obstetrics. In the 1980s and 90s rising intervention rates and dissatisfaction among service users led to criticism of the system and the re-emergence of midwife-led care slowly gained momentum. The midwifery model sees childbirth as a normal physiological event and midwives as experts in normality. The success of this role has been demonstrated in compelling evidence on the safety and effectiveness of midwife-led care for women (Sandal et al 2015) and from the Birthplace Study (The National Perinatal Epidemiology Unit (NPEU) 2015). This has led to The National Institute for Health and Care Excellence (NICE) advice that all low-risk women should be offered midwife-led care (NICE 2015a). This also demonstrates the increasing influence of evidence-based care in the process of measuring and supporting the value of the midwife in maternity care.

Midwives practise in a variety of settings. The vast majority of midwives work for the NHS, in hospitals, midwife-led units and community settings. There are also a small
number working in private practice although this may be less than a hundred following the NMC rejection of independent midwives’ insurance arrangements (NMC 2017). Midwives are responsible for providing care and advice to women/babies during pregnancy and birth and up to six weeks after birth. They are lead professional for women with low risk pregnancies and work in collaboration with obstetricians and other members of the multidisciplinary team to co-ordinate care for women with more complicated pregnancies. Midwives aim to enable women and their families to have a safe and positive experience of birth (DoH 2010)

Globally access to midwives is extremely variable with a strong association between high maternal and neonatal death rates and inadequate provision of midwives (United Nations Population Fund 2014). There is wide recognition that increasing the numbers of properly trained and educated midwives in countries where maternal and neonatal death rates are high has the potential to save millions of lives worldwide (Day-Stirk 2014). However, midwifery is far from being a straightforward concept. The Lancet series on Midwifery proposed that midwifery as an intervention is key to reducing maternity and neonatal mortality and morbidity worldwide (Horton and Astudillo 2014) and define midwifery care as:

‘…..skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life. Core characteristics include optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women’s individual circumstances and views; and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families.’

Not all qualified midwives engage in midwifery as defined above. In some countries the full scope of midwifery care is limited by cultural, legal, or philosophical barriers. The values and philosophies of midwives and the organisations they work in, may prevent some qualified midwives from practicing midwifery care. Moreover some doctors and some unqualified lay providers are able to provide aspects of midwifery very skillfully (Renfrew et al 2014). Thinking of midwifery as the intervention that supports the health and wellbeing of women and their families, rather than defining it only as something that midwives do, is not universally accepted. However, it is gaining acceptance as it keeps women and their families at the center when trying to understand what midwifery care is (Downe 2015).
3.3.4 **Suffering in Relation to Childbirth: The Elephant in the Room?**

The recognition and alleviation of suffering is a key aspect of compassion. It is not an obvious word of choice for midwifery which seeks to empower women with positive terminology rather than negative or frightening language (Byrom 2013, Furber and Thomson 2010, Hunter, L. 2006). Neither is it entirely alien, given the reality that many women do associate childbirth with pain and significant numbers of women do report suffering and trauma related to childbirth (Coates, Ayers and de Visser 2014). Arguably suffering is experienced by all people from time-to-time and several papers have noted the universality of suffering as part of the human condition (Cassell 1982, Davenport 2015, Sensky 2010). Although often thought to mean physical pain, it is different. A person feels pain in a part of the body (e.g. head, tooth, leg) but suffering is a whole person experience (Sensky 2010). Moreover, there can be pain without suffering and vice versa. Cassell (1982) points out that suffering can result from unacceptable changes, worries about the future or loss of autonomy. A Buddhist perspective sees ‘All life is suffering’ (or *Dukkha*) and teaches the practice of detachment as a path through this problem. In contrast, De Unamuno (1864-1936) accepted suffering a being an important part of what it is to be human and rather than detachment from it and an opportunity for growth and development (Dorling Kindersley 2011:4640).

The problem with the word suffering, in relation to Western healthcare at least, is that it appears to be out-of-step with current expectations and as such it has not been part of polite or professional conversations (Rodgers and Cowles 1997). In some ways it might be considered *not of our time*. One reason may be that it has strong religious links. Perhaps the iconic image of Christ, suffering crucifixion on the cross has something to do with why *suffering* is seen as an unpalatable word. It lacks a modern day perspective although definitions are useful. Roger and Cowles (1997) define suffering as a ‘subjective negative meaning attached to an event or perceived threat which may lead to feelings of loss of integrity, autonomy or control over a situation.’

This concept analysis will use the word ‘suffering’ as is consistent with definitions of compassion but its meaning in relation to compassionate midwifery acknowledges that it is part of the human condition. The researcher’s working definition for suffering around childbirth used in this thesis was:

‘The negative feelings of pain, distress or unease (which may be physical, psychological, emotional, social or spiritual) experienced by a woman during pregnancy, childbirth or the post-natal period’
3.4 Data Collection

Data collection was achieved through a search of Medline, Cinahl, PsycINFO and ETHOS using the search terms: compassion* and also for other terms closely related to compassion: empath*, kindness, emotional support, relationship-based. Each of these were combined with each of the following: midwi*, birth, childbirth, pregnan*, antenatal, prenatal, antepartum, labour, intrapartum, postnatal, postpartum, neonatal, breastfeeding (to capture all areas where midwives may be practising). Limiters were set to the words or terms appearing in the title or abstract, English language and between 1990 and 2015. However, seminal work prior to 1990 was referred to when appropriate (e.g. during a hand search of any selected paper which cited particularly influential work). In addition, a Google search for compassionate midwifery was carried out and an alert set up to monitor the internet for any new content on the concept. A flow diagram of the search strategy and results is shown in Figure 3-2. The total number of papers (and other works including book chapters and web based content) identified through the search strategy was 3215 once duplicates were removed. These were evaluated by reading the title and abstract to make an initial assessment as to appropriateness. Exclusions were made by title if there was no link to compassion or midwifery. Exclusions were made by abstract if there was no link to both compassion and midwifery, for example the term 'birth' was frequently used in ways that did not focus on childbirth. Works that were not considered relevant were discarded at this point. The remaining papers and other texts were read in full to consider relevance, focus and substance and eligible paper’s references hand searched for any new data. The final number of papers and other works was 73.
Figure 3-2 Results of the search strategy for concept analysis on Compassionate Midwifery

Reasons for exclusion: no midwifery or compassion relevance or, not substantial

Records identified through database searching
(n = 3511)

Additional records identified through other sources including Google Search
(n = 12)

Records after duplicates removed (n = 3215)

Excluded based on title
(n = 1784)

Excluded based on abstract
(1302)

Full-text articles assessed for eligibility
(n = 129)

Studies eligible for inclusion in review
(n = 73)

Full-text articles excluded
(n = 65)

Papers and other works included in review
(n = 73)
3.5 Data Management and Analysis

All papers were appraised and notes made which included general findings and key themes. Evolutionary concept analysis is an inductive, discovery approach to data analysis and focuses on using the data to identify the attributes and other contextual features of the concept (Rodgers 2000a). This process was a challenging one because actual definitions or even explanations about what compassion is in relation to midwifery were absent in the literature. Implied definitions and associations could be elicited by using Rogers’ (2000b) technique of repeatedly going back to the literature and asking the question: What is this thing that the writer is discussing?

3.5.1 Surrogate terms and relevant uses of the concept

Surrogate terms for compassionate midwifery were identified as:

- Compassion in midwifery
- Compassionate maternity services
- Compassion in maternity services

The last two terms refer to maternity services and therefore include other professionals in the maternity care team. Midwives are the biggest group in the multidisciplinary maternity care team and midwifery and maternity services are so closely related that these terms have been classified as surrogate terms rather than related terms. It was recognized that on occasion it may be impossible for women to differentiate between different professionals involved in their care.

3.5.2 References, Attributes, Antecedents and Consequences of the Concept Compassionate Midwifery

Appraisal of the literature revealed significant use of compassion (and words closely related to compassion) in relation to midwifery, but an absence of any meaningful analysis or explanation of what compassionate midwifery is. Understanding of the meaning of compassion in a midwifery context appeared to be either assumed or unspoken. Initially this was a major setback to progress with the concept analysis as the researcher’s journal entry below illustrates:

"I find it incredible that there is nothing of substance about compassionate midwifery out there. What I mean is nothing that really describes or defines it. It gets plenty of mentions but its meaning seems to be mostly assumed. I was feeling a bit despondent because I have been puzzling for days about what to do now. It is just so nebulous as a
Compassion in relation to midwifery care frequently appeared in the data and yet it remained poorly defined. However, compassion involves thoughts, emotions and behaviours around four different aspects of a compassion process as seen in Figure 3-1. By returning to this model and taking the different aspects of compassion: recognition (of suffering), emotion, motivation and action it was possible to see how the gathered data mapped onto these. This time the information was forthcoming and the four areas were not only visible but they clearly revealed ways the process of compassion is demonstrated in midwifery care. Each aspect of the process will now be explored using the literature in relation to midwifery practice.

3.5.3 Recognition
A number of papers indicate that to recognise a woman’s suffering a midwife must be available to her and have the sensitivity and skills to notice what is happening for her. Berg’s et al (1996) phenomenological study described women’s experience of the encounter with the midwife during childbirth and found that above all women must feel the midwife’s presence for positive interaction to be able to take place. The physical presence of a midwife when needed is the most obvious interpretation of presence and this is sometimes prevented by excessive workload or poor allocation and organisation of resources. It is obvious that in order to recognise a woman’s suffering she has to be there. One-to-one midwifery in labour has been associated with a range of improved birth outcomes (Hodnett et al 2013) and is therefore considered best practice (NICE 2014) but it has not been universally achievable (Care Quality Commission (CQC) 2018). However, there is more to presence than physical presence. Hildingsson and Rådestad’s (2005) study concluded that women want their midwife to pay close attention to them and to their partners. Berg et al (1996) found that the midwife’s presence incorporated treating the woman as an equal and with respect and also being in-tune with the woman and noticing her needs. She found that women can distinguish between midwives who are ‘authentically present’ and those who are ‘absently
present’. Absent presence describes the midwife who may be in the room but is not emotionally available to the woman and therefore not really seeing her and noticing her needs. The idea of authentic presence and absent presence was also recognised in a systematic review of women’s perceptions of breast-feeding support (Joanna Briggs Institute 2012). The review highlighted that authentic presence creates trust and connectedness between the woman and health care professional and reassurance that she is available for her when needed. Being truly present has been linked with spiritual care in midwifery Hall 2012, Lemay and Hastie 2018) and is sometimes called spiritual presence (Moloney and Gair 2015). This spiritual presence also refers to the midwife respecting the special or sacred aspects of childbirth and its place in both a woman’s life and the universe (Garratt 2001). Gaskin (2002:11) believes compassion is of foremost importance to spiritual midwifery.

Hunter L’s (2011) research, which analysed midwives’ poetry to interpret the experience of being with women during birth, identified that midwifery presence had a number of functions. These included keeping vigil, providing protection and safety, inspiring confidence in a woman’s ability to birth or ‘embodied power’. Other authors have described midwifery presence as watching and waiting or ‘holding a space’ for a woman to birth (Evans 2012, Seibold 2010).

Other characteristics in midwives which women value and that aid recognition of suffering are alertness (Tarkka, Paunonen and Laippala 2000), taking time and listening (JBI 2012, Raine et al 2010). Listening skills along with other communication skills would seem to be vital to the recognition stage of compassionate midwifery. However, midwives also need to be able to use their experience and intuition to interpret the very subtle cues that women may display in childbirth (Hunter, B. 2011, Leap 2000, John 2009).

3.5.4 Emotion
The data concurred with the premise that a compassionate midwife will recognise suffering and respond at the emotional level. This may initially be a sympathetic response which symbolises a human connectedness and solidarity, followed by an empathic response which not only demonstrates caring concern but also seeks to understand the nature of the suffering and the reasons for it. This empathic concern is highly valued by women and is an important part of the midwife/woman relationship (Nikula, Laukalla and Poikki 2015, Raine et al 2010, Wilde-Larsson et al 2011). Women
report feelings of vulnerability during childbirth (Simkin 1992) which lead to a need for someone to be caring, kind and emotionally close to them (Halldorsdottir and Karlsdottir 1996). A number of studies have linked the quality of the woman/midwife relationship to increased trust (Berg et al 1996, Davison et al 2015, JBI 2012, Lewis 2015, Williams et al 2010). While continuity of midwife supports the development of such relationships, many women are cared for in labour by a midwife they have never met. A number of authors have pointed to the quality of the relationship being central to high quality care and satisfaction with care (Bharjad and Chesney 2010, Howarth, Swain and Treharne 2012, Hunter et al 2008, Tinkler and Quinney 1998). Deery (2012) states that everything that midwives do connects to this relationship.

Several studies have investigated the emotional content of the woman/midwife relationship. John’s (2009) ethnographic study looked at emotion work between women and their midwives during labour and found that women used emotional management techniques to relate to their midwives to make their birth experience more positive. However, Carter and Guittar (2014) found that birthing women needed to process their emotions and this was carried out partly in solitude and partly with their midwife or birth partner. This emotional processing appears to be important throughout pregnancy and childbirth as it offers some protection against post-natal depression (Wilkins 2012).

Several studies have looked at empathic concern from the midwife’s perspective and the possible effects of repeatedly connecting at an emotional level in stressful situations and highly charged birth environments. There is some evidence that midwives are at risk of secondary traumatic stress and compassion fatigue (Leinweber and Rowe 2010, Rice and Warland 2013, Sheen, Slade and Spiby 2014). While it is important to acknowledge this, these specific problems will not be explored in this concept analysis. Nevertheless, the way midwives manage the emotional content of midwifery cannot be side tracked because it is connected to sustaining compassionate midwifery.

MacLellan (2014) drew attention to the emotional and professional balancing act that midwives encounter in their work. Hunter, B. (2006) studied the way community midwives cope with this emotional nature of their work using Hochschild’s (1983) framework of emotional labour. Hochschild’s (1983) seminal work with flight attendants identified two modes of emotional labour: the deep act which represents an authentic connection with another and a surface act utilised when there were difficulties with
communication preventing deep connection, yet there was a requirement to maintain a ‘professional face’. However, Huynh, Alderson and Thompson (2008) identified differences in the way emotional labour is carried out depending on professional norms and organisational rules. They outline the ‘work persona’ which may be employed during difficult encounters or situations when there is a perceived need to provide some emotional distance and self-protection and simultaneously maintain some emotional presence during caring. Schmidt and Diestel’s (2014) study with nurses revealed that surface acting (or work persona) was significantly associated with job strain whereas deep acting (or authentic connection) was unrelated. Rayment (2015) and Hunter and Smith (2007) have called for more research on emotion work in relation to midwifery. The emotional intensity and high stress levels in modern maternity care settings suggest that compassionate midwifery needs to include self-compassion and be extended to colleagues (Deery 2014).

Emotional Intelligence has been defined as ‘the ability to recognise our own feelings and those of others and it enables us to manage emotions effectively in ourselves and in our relationships’ (Patterson and Begley 2011) and it is considered essential to empathy (Goleman 2004:96). It is therefore an important characteristic for compassionate midwives. Emotional intelligence and self-awareness can support relationship-based, compassionate care and improve midwives’ capacity to deal with pressures at work and improves job satisfaction (Senel, Demirel and Sarlak 2009). There have been calls for emotional intelligence to have a much higher profile in the recruitment and education of midwives (Patterson and Begley 2011, Hunter 2009).

3.5.5 Motivation
The compassion process can only progress to support and assist women with the alleviation of suffering by moving through an emotional response to a behavioural response or action. The motivation to act may come from a variety of sources and will draw on the midwife’s knowledge, skills and experience. A midwife may take action to assist a woman because it is her job to do so. But this does not explain the experience of women who can clearly differentiate between midwives who take the time and trouble to assist them in appropriate ways and those who provide ‘standard care’ (Davison et al 2015, JBI 2012). Knapp (2015) implores midwives to ensure that their familiarity with birth does not ‘translate into routine actions’ without ‘a core of passion and compassion’.
Motivation to work with a woman to alleviate her suffering might be a result of a midwife’s ego, as it results in positive feedback and makes her feel good, or it may be related to a midwife’s altruistic disposition. But neither of these are compassion. It seems that it is the motivation to work with the woman and assist her to have the best childbirth experience that she can that is the essence of compassionate midwifery and it is closely connected to the nature of the midwife/mother relationship. Respectful, trusting, equal relationships place midwives in a position where they may genuinely want to empower women to have the best birth they can (Halldorsdottir and Karlsdottir 1996, and Hermansson and Mårtensson 2011). That is not to say that it is not underpinned by principles, values and beliefs. For example there is growing interest and support for the principles of human rights in childbirth (Prochaska 2015). This movement is of particular interest as it seeks to emphasise the feelings of vulnerability and powerlessness that can accompany pregnancy and birth and the importance of human rights law in protecting autonomous, respectful and dignified maternity care (Birthrights 2018).

Lack of motivation to act may be understood by examining circumstances where there is a serious lack of compassionate midwifery. Bohren et al’s (2015) systematic review of the global mistreatment of women during childbirth which spanned 34 countries illustrated how childbirth experiences are marred by mistreatment including abusive, neglectful and disrespectful care. Women commonly reported ‘mechanical care’ and not receiving the attention they needed. Factors contributing to mistreatment include staff shortages, overworked and underpaid staff, lack of training, lack of facilities and discrimination on the basis of race, socioeconomic status and medical condition. The review clearly demonstrates how organisational, situational, educational, personal and cultural factors all have an impact on the motivation and ability to provide compassionate care. It is of great concern how bad the lack of compassion can become given the right set of circumstances. There is evidence that midwives were actively involved in selective breeding programmes in Nazi Germany during the Second World War (Shields 2005). This is extreme but demonstrates the slippery slope of dehumanisation. Such examples are a reminder that human rights, cultural safety and ethical care re-inforce compassionate care, but also how compromised compassionate midwifery can become in environments where these are not the norm.

Several authors have pointed to the increasing emphasis on risk, in the NHS and particularly in maternity services, contributing to an environment of fear that midwives
work in. Byrom and Downe (2015), Gutteridge and Dahlen (2015) and Kirkham (2015) all describe ways in which a culture of fear impacts on midwives’ ability to be kind and compassionate. Fear of making an error, disapproval, recrimination, litigation, humiliation and possible loss of role and livelihood all contribute to fearful working. Campling (2015) and Youngson (2015) have linked this trend to suppression of compassion as fear becomes the dominant emotion. This is consistent with Gilbert’s (2009:123-147) work on the activation of the threat system.

3.5.6  Action

Women need actual help and ‘tangible support’ as well as emotional care (Iliadoiu 2012, Nikula Laukalla and Poikki 2015) and thus women need knowledgeable and skillful (as well as compassionate and kind) midwives (Gobena-Tricas et al 2011, Nicholls and Webb 2006). But this way of viewing midwifery as either practical or emotional is problematic when trying to understand compassionate midwifery because it creates a false separation. It is the combination of these two aspects which women value. Hill (2013) highlights the need for ‘competent care with compassion and patience’ when supporting women with perinatal addiction.

Midwives seek to work in partnership with women to address their needs and alleviate their suffering. A midwife may discuss various options about care with a woman, for example for pain relief in labour. This requires the midwife to explain the advantages and disadvantages of different pain relieving methods, thus facilitating informed choice while acting to help her manage her pain. The need to be able to communicate well to explain care options is supported in the literature (Raine et al 2010, Nicholls and Webb 2006). Frohlich and Schram (2015) call for the communication of risks and choices to promote knowledge, understanding and respectful compassionate care. Failure to explain and inform in a balanced way leads to women feeling that they are removed from decision-making and women describe the ill-effects of feeling that things were done to them rather than for them (MacLellan 2015). Similarly, The Joanna Briggs Institute noted that while women value practical care and support in relation to breastfeeding, the style and manner in which information is shared and help is offered is central to women’s perceptions of support (JBI 2012). Power sharing, alongside good communication skills are central to this.

The action part of compassionate midwifery may draw on all the midwife’s experience, knowledge and skills, including clinical skills. Scott (2015) describes the compassionate
care from a midwife following the stillbirth of her baby. She details how the midwife took photographs and video recordings of the baby for her and helped her to bathe and dress the baby and assisted the family to create a lifetime of memories in three days. However, action may mean not doing very much at all if that is appropriate. For example it may be that providing a calm environment, being authentically present, listening, reassuring or engaging in watchful waiting is the most appropriate action. In this way the midwife’s action is to engage the therapeutic use of self (Hunter and Deery 2009:8, Liberman 2013, Uys 1980) to alleviate suffering.

3.5.7 References
In a concept analysis references acknowledge the situations to which the concept is being applied and identify the scope of the concept. Compassionate midwifery proved to be a broad concept covering a range of situations and related behaviours. The analysis suggests it can be applied to a professional care encounter between a woman during pregnancy, childbirth or postnatal period and/or with her baby. It can also be applied to her birth partner or another member of her family or significant others. Equally it applies to the way a midwife cares for herself or for a colleague.

3.5.8 Attributes
The primary goal of concept analysis was the identification of its attributes as these amount to a real definition rather than a dictionary definition (Rodgers 2000a). The process of applying the compassion model (Figure 3-1) to the data resulted in identification of ten attributes. These were:

- Authentic presence
- Recognition of suffering
- Sympathy
- Empathy
- Connectedness/relationship
- Engaging in emotional work
- Motivation to help or support
- Seeking to empower the woman
- Negotiating ways to relieve suffering using shared decision making
- Using knowledge and skills to alleviate suffering in a way that is welcomed
3.5.9 **Antecedents**
Antecedents are what has to happen or be in place before a concept happens (Walker and Avant 2005:73) and a number of themes emerged from the literature which were seen as important or fundamental to compassionate midwifery. These were different approaches, skills and resources necessary for compassionate midwifery. Suffering was also identified as an antecedent because compassion is a response to suffering. Therefore, suffering has to be present before compassion.

3.5.10 **Consequences**
The consequences of compassionate midwifery are the aspects of the concept that were most supported in the literature. While data did not describe what the concept was it frequently described its desirability and benefits and how women have a need for it, therefore it was the consequences that were most easily identified. Attributes, antecedents and consequences are all listed in Table 3-2 below. The supporting literature is listed in a more detailed table at the end of this chapter (Table 3-6).
Table 3-2 Antecedents, Attributes and Consequences of Compassionate Midwifery

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>Attributes</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffering</td>
<td>Authentic presence</td>
<td>Trust</td>
</tr>
<tr>
<td>Partnership approach to care</td>
<td>Recognition of suffering</td>
<td>Maternal Satisfaction</td>
</tr>
<tr>
<td>Respect</td>
<td>Listening</td>
<td>Improved birth outcomes</td>
</tr>
<tr>
<td>Non-judgemental approach</td>
<td>Sympathy</td>
<td>Positive birth experiences</td>
</tr>
<tr>
<td>Sensitivity to suffering, Emotional intelligence</td>
<td>Empathy</td>
<td>Improved birth memories</td>
</tr>
<tr>
<td>Observation skills</td>
<td>Connectedness/relationship</td>
<td>Reduced fear of childbirth</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Engaging in emotional work</td>
<td>Reduced PND and reduced PTSD</td>
</tr>
<tr>
<td>Including listening skills</td>
<td>Motivation to help or support</td>
<td>Greater job satisfaction for midwives</td>
</tr>
<tr>
<td>Competence in clinical midwifery skills which may alleviate suffering</td>
<td>Seeks to empower the woman</td>
<td>Better working relationships/improved team work</td>
</tr>
<tr>
<td>Time and appropriate resources</td>
<td>Negotiating ways to relieve suffering</td>
<td>Improved health and wellbeing of midwife</td>
</tr>
<tr>
<td></td>
<td>using shared decision making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Using knowledge and skills to alleviate suffering in a way that is welcomed</td>
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3.5.11 Identify Related Concepts
Related concepts were identified as:

- One-to-one midwifery care
- Continuity of midwifery care
- Midwife-led care
- Human rights in childbirth

All four related concepts appeared in the data in relation to compassion or aspects of compassion. One-to-one midwifery, continuity of midwifery care and midwife-led care all support and potentially strengthen the midwife/woman relationship. Human rights in childbirth is related as it emphasises the rights of the individual and links compassionate maternity care to respect and dignity and women’s autonomy.

3.6 Develop a Model of the Concept

By using the contents of this table together with the references and surrogate terms a comprehensive Model of The Concept of Compassionate Midwifery has been developed and depicted in Figure 3-3. This model of compassionate midwifery builds on the Model of compassion in Figure 3-1 and organises the attributes of compassionate midwifery within the four phases of the compassion process.

3.7 Conclusions/Discussion and Implications for further development

This concept analysis has identified compassionate midwifery as a relatively unexplored and immature concept within the midwifery profession, in contrast to compassion in nursing, which has undergone closer scrutiny and study. Given the differences between the nature of nursing and that of midwifery a case for this concept analysis has been made. Identifying the concept first involved separate examination of both ‘compassion’ and ‘midwifery’. Compassion has proved to be a difficult concept to pin down but by identifying the distinct but related elements of compassion found within definitions a simple model was created of the compassion process (Figure 3-1). Some of the different words used for compassion and for aspects of midwifery care generated a range of key words on which to search for data. However, while there was data which appeared to explore or discuss compassionate midwifery or aspects of it, explanation of its inherent meaning was missing. For this reason it was necessary to return to the compassion process (Figure 3-1) and take each of the four aspects of compassion:
recognition, emotion, motivation and action and identify how the gathered data related these to midwifery care. This time the information was forthcoming and the four areas were not only visible but clearly revealed the attributes of the concept. In line with the model used, the antecedents, consequences and references were also identified during this process. These were then added to the model of compassion and a new model of the concept of compassionate midwifery proposed. The model of the concept of compassionate midwifery depicts the characteristics of the concept generated in the analysis and their relationship to the four elements of compassion and to each other (Figure 3-3).
A Model of the Concept of Compassionate Midwifery

Antecedents

- Suffering
- Partnership
- Respect
- Non-judgemental
- Sensitivity
- Emotional Intelligence
- Intelligent Kindness
- Observational skills
- Listening skills
- Communication skills
- Clinical skills
- Time and appropriate resources

Action

- Negotiating ways to relieve suffering using knowledge and skills to alleviate suffering

Recognition of suffering

- Authentic presence
- Listening
- Noticing

Motivation

- The desire, competence and confidence to support and empower a woman (colleague or self)

Emotion

- Sympathy, empathy, connectedness, relationship, emotion work

Attributes

Consequences

- Woman/midwife trust
- Maternal satisfaction with care
- Reduced fear of childbirth
- Women feeling more empowered
- Improved birth outcomes
- Positive experience and birth memories
- Improved bonding and early parenting
- Improved detection of PND and PTSD
- Improved job satisfaction for MW
- Improved working relationships/team work
- Improved health and wellbeing of MW

Reference: A professional care encounter between a midwife and a woman during pregnancy, childbirth or postnatal period and/or with her baby, birth partner/significant others. It may also refer to the way a midwife cares for herself or for her colleagues.
This concept analysis facilitated deep emersion, exploration and clarification of this emerging concept. The model proposed provided a theoretical starting point and potential for further analysis through a variety of means. Empirical studies provide the potential to take the process further by studying the experience of compassionate midwifery from a number of different perspectives. The model of compassionate midwifery will be developed and refined as new questions about compassionate midwifery are asked and studied. There might be a number of places to start this process. It could focus on the midwife’s experience or look at the influence of compassion on midwifery education or maternity policy. However, the lack of data regarding how women experience compassionate midwifery care makes this a compelling starting point. Midwives, educationalists, managers and policy makers may be better placed to ensure compassion in midwifery practice if they understood more about women’s experience of compassionate midwifery. The idea for this study was conceived on this premise.
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<tr>
<th>Year</th>
<th>Document or event</th>
<th>Reference</th>
<th>Emphasis</th>
<th>Associated Care Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>Midwife Information and Resource Service (MIDIRS) set up</td>
<td>Anderson (2006)</td>
<td>A body of knowledge on which to base midwifery</td>
<td>Evidence-based care</td>
</tr>
<tr>
<td>1987</td>
<td>Where to be Born? The debate and the evidence</td>
<td>Campbell and MacFarlane (1987)</td>
<td>Questions majority of births in consultant led units. Emphasis on midwife's role</td>
<td>midwife-led care</td>
</tr>
<tr>
<td>1997</td>
<td>The New NHS Modern Dependable</td>
<td>DoH 1997</td>
<td>Raising standards through Clinical Governance</td>
<td>Accountable care</td>
</tr>
<tr>
<td>2007</td>
<td>Maternity Matters</td>
<td>DoH (2007)</td>
<td>Promotion of normal birth, choice, access, continuity</td>
<td>Supportive care</td>
</tr>
<tr>
<td>2011</td>
<td>The Birthplace Study</td>
<td>National Perinatal and Epidemiology Unit (2011)</td>
<td>Safety of place of birth in different settings</td>
<td>Midwife-led care</td>
</tr>
<tr>
<td>2012</td>
<td>Compassion in Practice</td>
<td>Cummings and Bennett (2012)</td>
<td>The six Cs Compassion,</td>
<td>Values-based Care</td>
</tr>
<tr>
<td>Author/Source and year</td>
<td>Origins or type of work</td>
<td>Definition</td>
<td>Emotion</td>
<td>Motivation for action</td>
</tr>
<tr>
<td>------------------------</td>
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<td>-----------------------</td>
</tr>
<tr>
<td>Collins English Dictionary (2015)</td>
<td>Dictionary</td>
<td>‘feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Oxford Dictionaries (2015)</td>
<td>Dictionary</td>
<td>‘sympathetic pity and concern for the sufferings or misfortunes of others’</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Taliaferro (2010)</td>
<td>Dictionary of Philosophy and Religion</td>
<td>‘Literally “feeling with” a compassionate person is one who empathizes (or sympathizes) with those believed to be harmed and is disposed to go to their aid’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Jonas (2005)</td>
<td>Dictionary of Complementary and Alternative Medicine</td>
<td>‘a profound awareness of another’s suffering coupled with a desire to alleviate that suffering’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Robin Youngson (2012)</td>
<td>Book: ‘Time to Care’</td>
<td>‘the humane quality of understanding suffering others and wanting to do something about it’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Miller-Keane and O'Toole (2005)</td>
<td>Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health</td>
<td>‘a virtue combining concepts such as sympathy, empathy, fellow feeling, benevolence, care, love, and sometimes pity and mercy. These are character traits that enable professionals to use their cognitive and psychomotor skills of healing to meet the needs of a particular patient. The need for particularity in the healing relationship makes compassion a moral virtue’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Gilbert (2009)</td>
<td>Book: ‘How to be Compassionate’</td>
<td>‘a basic kindness, with a deep awareness of the suffering of oneself and other living things. Coupled with the wish and effort to relieve it.’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Wikipedia (2015)</td>
<td>Online Encyclopaedia</td>
<td>‘The response to the suffering of others that motivates a desire to help’</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Von Dietze and Otb (2000)</td>
<td>Published paper</td>
<td>‘Compassion holds us in the balance between working in solidarity with the sufferer to eliminate the suffering while not making the mistake of simply transferring that suffering onto ourselves’</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Cummings and Bennett (2012)</td>
<td>DoH Strategy</td>
<td>‘Compassion is how care is given through relationships based on empathy, respect and dignity’</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Word</td>
<td>Origin</td>
<td>Definition</td>
<td>Sensitivity to suffering</td>
<td>Feels sorry for</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Pity</td>
<td>From 12th and 13th Century word. Old French and Latin <em>pité</em>, <em>pitet</em> and Middle English <em>pity</em></td>
<td>Feeling of sorrow for the suffering of another</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sympathy</td>
<td>From the Greek <em>syn</em> (together) and <em>pathos</em> (feeling or suffering)</td>
<td>Solidarity for another in their suffering</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Empathy</td>
<td>From Greek <em>en</em> (in or at) and <em>pathos</em> (feeling or suffering)</td>
<td>The human quality of understanding the suffering of others</td>
<td>Yes</td>
<td>Not necessarily</td>
</tr>
<tr>
<td>Kindness</td>
<td>From old English <em>gecynde</em> (with the feelings of family/kin) and Proto-Germanic <em>kundjaiz</em> (family/race)</td>
<td>The quality of being generous, considerate, friendly and deliberately doing good to others</td>
<td>Yes</td>
<td>Not necessarily</td>
</tr>
<tr>
<td>Altruism</td>
<td>From old French and Latin meaning <em>of or to others</em></td>
<td>The principles and practice of concern for the welfare of others</td>
<td>Likely</td>
<td>Not necessarily</td>
</tr>
<tr>
<td>Compassion</td>
<td>From late 12th century Latin means <em>feel together</em></td>
<td>The feeling that arises in witnessing another’s suffering and the desire to help</td>
<td>Yes</td>
<td>No necessarily</td>
</tr>
<tr>
<td>Antecedents</td>
<td>Attributes</td>
<td>Consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time and appropriate resources (Kirkham 2010, JBI 2012)</td>
<td>Using knowledge and skills to alleviate/prevent suffering/distress in a way that is welcomed (Nicholls and Webb 2009, JBI 2012, Knapp 2015)</td>
<td>Better working relationships/team work (Patterson &amp; Begley 2011, Walsh &amp; Devane 2012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 4 Methodology

4.1 Introduction

Chapter 3 examined the widespread use of the word compassion in relation to nursing and midwifery and demonstrated that it remains an elusive concept. While the literature provided evidence of significant examination of compassion in relation to nursing, compassionate midwifery is an unexplored and underdeveloped concept. However, the desirability of compassionate midwifery is evident (Byrom and Downe 2015:9-12) and the nature of the interactions between midwives and women during pregnancy, childbirth and the early postnatal period has lasting consequences on women's health and wellbeing (Moloney and Gair 2015, Tarkka, Paunonen and Laippala 2000). While there are many accounts of women's mistreatment or lack of compassion by midwives and other birth attendants throughout the world (Bohren et al 2015), the literature in Chapter 2 and Chapter 3 revealed that there was very limited evidence and no robust research exploring what compassionate midwifery means to women. The concept analysis of compassionate midwifery in Chapter 3 of this thesis drew on academic and grey literature to identify the antecedents, attributes and consequences of the concept and from this a conceptual model was produced. This provided a starting point and an organising framework for the concept but it was unqualified and untested without empirical research with which to compare, contrast and develop it. Chapter 3 highlighted that the concept analysis was unable to truly define compassionate midwifery and could not reveal how it is actually experienced, therefore to move forward, research was required.

A number of different stakeholders might be expected to have opinions on what compassionate midwifery is and how it is experienced. However, the limited understanding of service-users' experiences of compassion, which was highlighted in a substantial scoping review (Sinclair et al 2016), provided direction when setting the research question. Because service-users' perspectives on the nature of compassion have been so neglected in healthcare research, this study sought to make their views a priority. Therefore, to understand the experience of compassionate midwifery it was the women who receive midwifery services who were selected as those most qualified to reveal the nature of their experience. This choice led to the formulation of the research question, aims and objectives. These were guided by methodological theory and in turn this led to the methods for the study. This chapter will explore the underpinning
methodological theories which have guided the approach to this study and strongly influenced its design, demonstrating the importance of good methodological fit between the research question, theoretical underpinnings, data collection and analysis (Sullivan, Gibson and Riley 2012:66). This chapter seeks to explain how the methodology supports the research question and justifies the methods which are theoretically appropriate. In this way it sets the scene and builds the rationale underpinning the data collection and analysis methods in Chapter 5.

4.2 Research Question, Study Aims, Objectives and Overall Design

4.2.1 Research Question
What is compassionate midwifery from the perspective of the women who use maternity services?

4.2.2 Aim
To develop a deep understanding of the lived experience of compassionate midwifery to inform practice, education and service provision and guide future research in this area.

4.2.3 Objectives
- To identify women who believe they have personally experienced compassionate midwifery care.
- To identify the ways in which women experience compassion in midwifery.
- To explore women’s thoughts and feelings about compassionate midwifery care.
- To gain an understanding of the impact of compassionate midwifery on women.

4.2.4 Overall Research Design
The overall design is an exploratory, qualitative study underpinned by the principles of interpretive phenomenology and informed by an appreciative approach and feminist theory. Semi-structured interviews were chosen for data collection and data analysis utilised an Interpretive Phenomenological Analysis (IPA) approach.
4.3 Qualitative Research

The quantitative research tradition is concerned with what is measurable and the numerical and statistical analysis of data collected as a means of testing or quantifying something. O’Dwyer (2013:44) explains that it is fundamentally an approach to seeking new knowledge by simplifying complexities, usually within settings that tend to be manipulated or contrived. This can be compared with qualitative research which is conducted in natural settings and embraces complexity. Quantitative research is based on a world view or paradigm grounded in a realist ontology, objective/dualist epistemology and experimental, hypothesis-based methodology. Qualitative research is based on a range of alternative paradigms and has been developing since the beginning of the twentieth century and continues to develop (Denzin and Lincoln 2013:5). It therefore incorporates a range of ontological positions which broadly reject realism in favour of more relativist positions and interpretive epistemologies which take into account the socially constructed nature of reality (Walker 2015:37-38). In this way qualitative research is a broad church as it is used to study many different disciplines and may utilise numerous methodologies and methods. However, the common denominator is that qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2013:3). While some of the more traditional scientific healthcare journals continue to view qualitative research as less rigorous, increasingly this is robustly contested (Greenhalgh et al 2016). Moreover, there is now widespread acknowledgment that a pluralist approach to healthcare research is beneficial, where it is acknowledged that there is no single ‘best way’ and diverse approaches can be used. More than one approach can be used separately or there can be blending and synthesis. In this way different methodologies can borrow from each other in order to be refined (della Porta and Keating 2008:17). What matters is that the research methodology aligns to the research aims (Greenhalgh et al 2016). The quality of research can be seen as being defined not by the superiority of any one research paradigm over another but by the transparency of the research philosophy and methods (Bunniss and Kelly 2010).

Qualitative research findings are not generalisable in the same way that quantitative research asserts, instead the transferability and applicability of findings to other settings and groups should be considered (Guba 1981; Morse 2015). This is discussed in Sections 7.2 and 7.10.
Qualitative methodology is justified for this study as the aim was not to measure or classify anything or to elicit cause and effect. The aim of this study was to develop a deep understanding of the experience of receiving compassionate midwifery, therefore a qualitative approach fitted this aim as it focusses on how people make sense of their experience in the world (Holloway and Wheeler 2013:3) and the thoughts and feelings that accompany it (Ingham-Broomfield 2015). Moreover, a qualitative approach is an established strategy for exploring a phenomenon when very little is known about it, as in the case of compassionate midwifery (Campbell 2014). Such exploration of a subject may be an important forerunner to further work on developing theory (Burns and Grove 2009: 360).

4.4 Interpretive Phenomenology

As little is known about the phenomenon of compassionate midwifery, in this study a phenomenological approach facilitated discovery and description of the phenomenon by attending to the experience itself and asking: ‘What is this thing?’ and ‘What is going on here?’ Phenomenology has been described as a way of thinking which seeks to discover through openness and genuine curiosity (Finlay 2014). Converse (2012) has described how its history began with the work of Husserl in the early 1920s and has been developed and modified in a number of different ways. As a result it encompasses a range of related philosophical perspectives rather than one unified methodology. Significantly, the work of Heidegger in the 1920s (Cerbone 2008:31) and later that of Gadamer (1975) has been linked with the inception and early development of interpretive phenomenology and hermeneutics, which is the study of interpretation (Moran 2002:248). Interpretive phenomenology goes beyond description and attempts to reveal the deeper meaning and insights associated with experiences that individual people have.

This project design draws on the principles of interpretive phenomenology as it recognises the unique and authentic meanings inherent in being in the lived experience, as described in the work of Heidegger and Gadamer. The lived experience refers not only to a person's experience of events or occurrences, but how they give meaning to their situation through personal stories or 'subjective streams' (Dierckx et al 2011, Paley 2014b). Therefore interpretive phenomenology fitted well with the aims and pushed the study beyond descriptions of what midwives said or did. It sought to understand women's lived experience of compassionate midwifery. Theoretically it
aligned with both the purpose of the study and the researcher’s philosophy, which was that a phenomenon is experienced and interpreted by individuals in different ways as it is shaped by many factors including past experiences, personality and values. Moreover experience is always interpreted within a cultural, social and political context.

### 4.5 Methodology and its Influence on the Research Process

There is a widely held view that methodology (the philosophical guide for research) should lead to the methods (the ways and means of doing the research). Others have argued that the complexity of problems studied in research justify deviations from this ideal (Pope and Mays 2006:2-3). This has led to controversy between those who stress the importance of traditional and disciplined approaches to methodology and methods and those who use them in ‘*a spirit of careless rapture*’ (Coffey and Atkinson 1996:11). These opposing views can be resolved by a middle way approach in which there is both coherence and flexibility (Holloway and Todres 2003). The ‘researcher as *bricoleur*’ can borrow from different areas, as if selecting the right combination of tools and materials for their craft (Denzin and Lincoln 2013:7). This was the approach favoured when designing this study in that the selected combination of methodology (and, as a result methods) provided the right tools and materials, building coherence of aims, philosophy, methodology and methods. As a result interpretive phenomenology guided the study but it was coloured by feminist theory. Interpretive Phenomenological Analysis (IPA) was used in conjunction with some of the principles of Appreciative Inquiry (AI) in an innovative approach to data collection and analysis which was well suited to the studies aims.

An interpretive phenomenological approach to research requires data collection methods which are consistent with the aim of gathering rich descriptions of participant’s experience without reference to external theories (Holloway and Todres 2003). In this study data from women was collected using semi-structured interviews and IPA was used to analyse data. While data collection and data analysis processes will be discussed in more detail in Chapter 5 it is useful to acknowledge how methodology influenced the choice of methods.

IPA was chosen as an appropriate and coherent method of enquiry for this study but, in choosing IPA, a number of other methods of analysis were considered and rejected. Grounded theory was seriously considered for its focus on clinical or practical relevance of findings (Hussein et al 2014). However, in grounded theory the literature
review is usually completed after analysis (Glaser and Strauss 1967) and as a concept analysis had already interrogated the literature, this would not be possible. Additionally grounded theory examines how things happen through social interactions and how social structures and processes influence this (Cutcliffe 2000). Although this was certainly of interest, there was so little known about what compassionate midwifery was that IPA provided a better fit when trying to understand what individual women actually experienced and the sense they made of it. Discourse analysis was considered but rejected as its focus is on the actions or intentions implicit within language (Starks and Trinidad 2007) and it was felt that this would not adequately capture the experiential focus of research question. Braun and Clarke’s (2006) thematic analysis was rejected as, although it is a very adaptable and widely used method of organising qualitative interview data, it is predominantly descriptive and has limited interpretive qualities when compared to IPA.

4.5.1 **Interpretive Phenomenological Analysis (IPA)**

IPA, first described in a seminal paper by Smith (1996) was selected for this study for several reasons. Firstly its philosophical principles aligned with phenomenology and intellectually connected to hermeneutics (the study of interpretation) and was therefore appropriate for a study which sought to understand experience. Secondly, IPA goes beyond this as it offers methodological principles and systems for interpreting lived experience (Smith, Flowers and Larkin 2009:1). While phenomenology can be seen as the overarching methodology for this study, IPA encompassed that and provided method or process. Interpretive phenomenology provides a philosophy but IPA synthesises this philosophy and operationalises it within a systematic yet flexible research framework, thus offering the complete package of theory and method (Smith, Flowers and Larkin 2009:200-201).

IPA is an empathic method in that it seeks to understand what it is like to be in another’s shoes while simultaneously trying to interpret that experience (Shaw 2011). Uniquely, it specifically requires the researcher to attempt to make sense of the participant, who is herself, trying to make sense of her experience. Consequently it is described as having a ‘double hermeneutic’ (Smith and Osborn 2015:26). In this way it respectfully acknowledges the contribution of both the participant and the researcher in the findings (Biggerstaff and Thompson 2008).
The double hermeneutic in IPA raises questions about how much the researcher’s interpretations are influenced by their own perspectives and pre-understandings or what Smith (2004) calls their biographical presence. The practice of attempting to ‘bracket’ these off so that they do not influence aspects of a study is advocated within Husserlian phenomenology. However, this is somewhat controversial in IPA. Biggerstaff and Thompson (2008) suggest that while bracketing is needed in early stages of engagement with the data, the interpretive process demanded by IPA calls for engagement with the researcher’s personal biases. Rather than separation from these through bracketing the researcher engages in a fundamental aspect of IPA, that of reflexivity (Wagstaff et al 2014). To this end, as discussed in Section 1.4 and illustrated in Section 5.5.4 and elsewhere in this thesis, reflexive journal notes were used. These assisted in making sound interpretations through self-awareness and reflection on the researcher role and the possible influences on the researcher’s interpretations. This allowed reflexivity to evolve as an active process in this study, illuminating pre-conceived ideas, interests and biases which could then be considered and revealed in an effort to acknowledge the complexity of meaning-making, and increase the rigour of the research (Clancy 2013, Lambert, Jomeen and McSherry 2010). This sensitivity to and reflexivity with the participant’s story, ideas and concerns and with the researcher’s position and pre-understandings, should not be seen as an alternative to bracketing. Rather, it should be seen as a dynamic and nuanced form of bracketing (Cassidy et al 2011).

Embarking on an IPA study, following a concept analysis, facilitated the examination of compassionate midwifery from two very different perspectives. In the absence of information about what compassionate midwifery was, the concept analysis provided a broad and outward looking investigation on the concept of compassionate midwifery. It attempted to answer the question: what is happening out there? This reveals how this concept is widely thought of and used. Conversely, studying lived experience with an IPA study focussed on what was happening in there for individual women who experience compassionate midwifery? Selecting these two methods enhanced understanding by moving from one unit of understanding, and context, to another. In this way it was entirely consistent with a hermeneutic approach in which meaning develops through understanding different parts of the whole.
4.6 Adopting an Appreciative Approach

In conjunction with an interpretive phenomenological methodology and IPA method some of the principles of Appreciative Inquiry (AI) were utilised. The theory of AI holds that everyone in an organisation can use knowledge from positive outcomes to learn and make improvements (Trajkovski et al 2013). This study did not entirely fit the description of AI which is a form of action research, however, it did ‘borrow’ an appreciative approach from AI. AI uses the positive principle and therefore AI studies concentrate on what people appreciate and value rather than on what is unwanted or deficient (Reed 2007:2). By ‘unpacking’ women’s positive experiences of compassionate midwifery, enhanced understanding emerged. In addition, dissemination of findings within the midwifery profession is more likely to be accompanied by a ‘positive emotional climate’ as it is easier to hear about what has gone well rather than what went wrong (Onyett 2009). Importantly, it may also be easier to learn from the presence of compassion, rather than from an absence of it. While reports about midwifery care lacking in compassion are important and sobering for the profession, studies which focus on the positive may lead to improved learning about compassionate midwifery and ways of supporting and purposefully eliciting it. This is explained by the anticipatory principle inherent in an appreciative approach (Cooperrider 1986). This principle asserts that people engage more easily and for longer with the positive and that more effort and energy will be directed towards developing a future based on recognising, expanding and sustaining what is good rather than what is bad. (Reed 2007:26-29).

While it might be argued that collecting data from participants who identified that they had experienced compassionate care was in effect just a purposive sample and nothing unusual for IPA studies, there is more to it than that. Although it is common for IPA studies to recruit purposive samples to achieve homogeneity (Smith, Flowers and Larkin 2009:48-51) they more often study difficult or even negative experiences. Indeed, IPA has been seen as particularly appropriate for studying the lived experience of illness, pain or loss (McTiernan and O’Connell 2013, Snellgrove and Liossi 2012). A number of IPA studies have explored difficult, negative and traumatic experiences relating to pregnancy and birth (Baird and Mitchell 2014, Feeley and Thomson 2016, Harper et al 2011, Mercer, Green-Jervis and Brannigan 2012, Ustundag-Budak et al 2015). However, the research question for this study sought to understand the lived experience of compassionate midwifery, not its absence, therefore the methods used
embraced the more unusual approach of seeking to understand positive experiences. This study demonstrated that IPA used in conjunction with the key principles of AI (that of appreciating what has gone well) synthesised a positive approach from AI together with considerable depth, detail and authenticity from interpretive phenomenology, which duly addressed the research question.

4.7 A Feminist Theoretical Lens

Researchers declaring a feminist perspective need to be explicit about what makes their work feminist (Gringeri, Wahab and Anderson-Nathe 2010). Yet feminism is not a unified project (Letherby 2003:4). Feminist research perspectives are as varied and nuanced as the range of feminisms that underpin them (Gringeri, Wahab and Anderson-Nathe 2010). Therefore, adequately justifying a feminist stance and clearly aligning this with the research aims, methodology and methods can be a complex task (Gray et al 2015). While feminist research has no universal definition, it is often referred to as research that is primarily by, for and about women (Brayton, Oliver and Robbins n.d). However, Gray et al (2015) argue that it must be more than this, claiming that feminist research must also be able to take women’s ‘location in and perspective on, the world’. While there is much controversy and disagreement on how best to accomplish this, Gray et al (2015) have cut through some of the complexities by highlighting three guiding principles on which all feminist theorists are likely to agree which are:

- understanding women’s experiences
- seeking to improve women’s lives
- addressing the balance of power in the relationship between the researcher and the researched.

These three clear principles provide an opportunity for both researchers and professionals reading and evaluating research to develop a broad feminist position without having to identify with one particular branch of feminist theory. Midwives and midwifery researchers, despite identifying with their role ‘with woman’ have been surprisingly reluctant to bring a feminist lens to their work (Walsh, Christianson and Stewart 2015). This has resulted in a current lack of feminist midwifery research or academic discussion on midwifery’s links to feminist issues. Although many feminist social scientists have studied childbirth (Kitzinger 1978, 2005; Oakley 1979, 1982, 1986), far fewer midwifery researchers have utilised a feminist approach, with a
spattering of notable exceptions including Kirkham (1999) and Leap and Anderson (2008:29-46). Reasons for this may be around internalised negative stereotypes of feminists together with a lack of exposure to feminist research in midwifery undergraduate education (Walsh, Christianson and Stewart 2015). In addition the methodological intricacy, sociological jargon and complex language of academic feminist works can make them ‘utterly inaccessible’ (Hanisch 1999). Yet feminism has much to offer midwifery and vice versa. Fundamentally, they are both about the empowerment of women (Yuill 2012).

Midwives' unique role with and for women at and around the time of childbirth puts them in a perfect position to embrace the feminist lens in research but they are unlikely to do this unless they recognise its relevance to midwives and to the women and families they support. Those involved in midwifery research must find ways of addressing this if feminist values and gender equality are to become central to midwifery theory and practice (Walsh, Christianson and Stewart 2015).

This study does not purport to be feminist research. However, a feminist lens, based on Gray et al’s principles, informed the aims and research design. It also informed aspects of the analysis and the discussion, in particular that found in Section 7.5 of this thesis. These principles provided a lens for informing research into women's experience of compassionate care from midwives. The following three sections explain the ways in which Gray et al’s (2015) principles informed the research aims and design.

**Understanding Women’s Experience**

Historically medicalisation has reduced childbirth to a male-dominated medical speciality. Within this, a mechanistic view of women’s bodies was favoured over the authentic experience of birth and motherhood (Yuill 2012). Despite the increase in female obstetricians, recognition of the value of midwife-led care and the introduction of woman-centred maternity policies, the legacy of male-dominated childbirth continues to be hard to shake off (Yuill 2012).

Feminist theory considers childbirth as not only a biological imperative, physiological process and a life-changing event in individual women’s lives but also explores it within a social, economic and political context. As such, childbirth is inextricably linked to the role of women in society and the gender power dynamics within that society. Moreover, from a theoretical perspective it poses epistemological questions about knowledge and
‘who can know’ which have influenced the design of this study. Letherby (2003:24-28) differentiates between highly valued ‘authorised knowledge’ which has evolved to be masculinised and androcentric and ‘experiential knowledge’ which is built up through everyday experience and which has been undervalued and suppressed. Women’s ways of knowing confronts authoritative knowledge and provides a powerful resource for knowledge development (Dixon, Skinner and Foureur 2013a). This study seeks to develop knowledge about compassionate midwifery by valuing experiential knowledge and recognising women themselves as ‘knowers’ regarding the compassionate midwifery care that they have received. It is the women who experienced compassionate midwifery and who know what it is to them, who in this study are valued as the experts and empowered to share their knowledge. Valuing women’s knowledge, empowering them to share it and developing knowledge from this are established feminist principles (Ruchti 2012) and they have informed the aims and design of this study.

**Seeking to Improve Women’s Lives**

The rationale for this study is rooted in an understanding of the need to improve women’s lives. While the scope of the study is confined to understanding women’s experience, the reason why this understanding is needed is to inform practice, education and service provision which can, in turn, improve care. The widespread call for midwives to be compassionate has been presented in Section 2.5 of this thesis and the concept analysis in Chapter 3 testifies to the absence of research on the subject. Thus, it is anticipated that this study will support increased knowledge around compassionate midwifery practice. Arguably if midwives can understand how women experience compassion from midwives they will be better equipped to provide such care. This in turn has the potential to contribute to improve women’s childbirth journey.

**Addressing the Researcher-Participant Balance of Power**

Feminist perspectives of the research process draw attention to the unequal balance of power between the researcher and the participants and this has been a key consideration within this study. Midwifery is an ancient role but has only been a regulated profession in the UK since the 1902 Midwives Act (Stevens 2002) and its history within the medical-dominated model of childbirth has already been described and critiqued extensively (Wagner 1996; Johanson, Newburn and McFarlane 2002; Beech 2011). However, the role of the midwife in being ‘with woman’ as a support
during childbirth is also well established and valued. This has been strengthened because midwifery itself has been shown to be a very effective intervention (Sandall et al 2015). It is not surprising that midwifery finds itself commonly misunderstood (Horton and Astudillo 2014). It is in the difficult position of being part of the healthcare establishment (which decides how childbirth should be managed) and as such women may see midwives as authority figures. However, they are also in service to women, standing by them as supporters and partners (Cooper and Lavender 2013; Ménage 2016; Newburn 2006). Therefore within this study there was a keen awareness of this complex situation which has been reflected in study design and by attending to reflexivity.

Power dynamics never disappear (Gray et al 2015) but in this study the researcher sought to reduce their impact through the study design. This was achieved by using methods which value individual women’s experiences and use minimal direction or suggestion. In addition, the interviews were conducted within the privacy of their own homes and always at a time to suit them. The study design assisted in maintaining an equitable and respectful research partnership. In addition, reflexivity through the regular use of a journal enabled further attendance to issues relating to the researcher/participant relationship and in particular reflection on how past experiences, attitudes and values impact on this relationship and on research. Reflexivity offered a useful tool with which to conduct self-critical yet compassionate reflection on all aspects of the study (Medved and Turner 2011) and also sought to acknowledge and address researcher/participant power dynamics in this study.

Phenomenology has been used extensively by feminist researchers to study women’s experiences thus breaking away from pre-conceived ideas and assumptions about women’s lives and learning about their lived experience (Arpanantikul 2003, Baird and Mitchell 2014, Thomson, Dykes and Downe 2011). A phenomenological approach was selected for this study because it was consistent with valuing women’s lived experience. Moreover, blending interpretive phenomenology with an appreciative approach and utilising the IPA process gave voice to individual women’s perspectives from their individual world view, valuing the meaning they assign to their positive experiences of compassion from midwives. The Theoretical and Methodological Model shown in Figure 4-1 depicts the logical relationship between the methodology, theoretical lens, method, and approach and research question.
Conclusion

This chapter began by summarising the key issues from the literature review and concept analysis to formulate the research question, aim and objectives and then proceeded to outline the overall study design. Qualitative as opposed to quantitative research methodology was justified and the manner in which research was guided by philosophical positions was explored. Interpretive phenomenology was identified as the methodological guide for this study. The desirability of congruence between methodology and methods led to the rationale for using IPA enhanced by an appreciative approach. While the research design is not overtly feminist, a feminist theoretical lens based on Gray et al’s (2015) principles for feminist research has informed aspects of this study. Moreover, the case has been constructed for a logical and consistent link between methodology, methods and research aims, through an innovative but fit-for-purpose blending of theories and approaches. This methodological model is depicted in Figure 4-1. While this chapter has focussed on the philosophical and theoretical aspects of the research design, Chapter 5 will focus on the study methods.
Figure 4-1 Theoretical and Methodological Model for the Study

Overarching Paradigms: Relativist Ontology & Interpretivist Epistemology

Theoretical Lens: Feminist

Methodology: Phenomenology

Ask: What is this thing?
(Compassionate Midwifery)

Approach to method: Appreciative

(Compassionate Midwifery)

Method: IPA

Interpreting how women interpret their lived experience of compassionate midwifery

Research Question: What is women’s lived experience of compassionate midwifery?
Chapter 5 Methods

5.1 Introduction

Chapter 4 explored the theoretical underpinnings and methodology for this study. Chapter 5 will move on to concentrate on the methods used to carry out the study, starting with the setting selected for the study and recruitment of the sample. Ethical considerations will be considered and outlined before detailing the data collection methods used with women participants in the study sample. The methods used for handling, storing and analysing the data will then be described and the ways in which quality has been addressed within the study methods is explored.

5.2 Study Setting

Participants were recruited through two large National Health Service (NHS) Trusts in The Midlands in England. These were:

Hospital A: A small/medium unit with seven birthing rooms. At the time of the study there was no midwife-led birth centre. The Trust had approximately two and a half thousand births per year. Three per cent were home births.

Hospital B: A large teaching hospital. The Women and Children’s unit includes a large consultant-led delivery suite and an alongside midwife-led birth centre with thirteen birthing rooms in total. At the time of the study the Trust had approximately six thousand births per year. One percent were home births.

Women eligible for recruitment to the study had given birth (or intended to give birth) in a consultant-led unit, a midwife-led unit or at home. Permission for the study was granted from the Heads of Midwifery and Research and Development leads at both Trusts, subject to ethical approval. Data collection took place in women's own homes or in an alternative place of their choosing.

5.3 Recruiting to the Study

Recruitment took place between June 2016 and January 2017. The sample consisted of seventeen women who identified themselves as having received compassionate care when they used maternity services. Posters which asked women if they had experienced compassionate midwifery care were displayed in the antenatal and
postnatal wards, antenatal clinics and at antenatal classes (see example poster/leaflet in Appendix 12.2). Leaflets with identical information were given to women being discharged from midwifery care in the postnatal period, along with their routine discharge paperwork. Posters and leaflets targeted women who were either pregnant or who had used maternity services within the last four weeks. The intention was to interview women about their experience while they were still pregnant or within the first few weeks of birth. Although there is evidence that women carry memories from their birth for the rest of their lives (Simkin 1992) some studies have indicated that memories may change slightly over time (Takehara et al 2014, Waldenström 2003, 2004). By interviewing new mothers within a few weeks of birth, while memories were fresh, it was anticipated that they would also be more likely to be able to recall the conversational details, thoughts, feelings and other specific characteristics of their experience. Although the literature does not provide enough clarity to guide an optimal time to interview new mothers a decision was made to interview women up to a maximum of ten weeks post birth. However, recruitment posters and leaflets targeted women up to four weeks post birth. This prevented situations in which prospective participants were declined because they had been busy with their new baby and not contacted the researcher in time. Importantly, it allowed plenty of time to send out information packs, answer questions and ensure fully informed consent. It also achieved a realistic timeframe to ensure lots of flexibility when negotiating arrangements for interviews with new mothers.

This purposeful sample was recruited in accordance with the study’s aims and approach of seeking to appreciate and understand the lived experience of compassionate midwifery for women who believe they have received such care. Women who responded to a poster or leaflet were invited to text or email the researcher with the word ‘compassion’. The researcher then phoned the potential participants and briefly explained the study and sought consent to email or post a study information pack. This system usually worked well except on two occasions when it emerged that it was not the woman but her male partner who had contacted the researcher and who wanted to be interviewed about their experience. This was a sensitive situation as neither of these men’s partners sought involvement in the study. Therefore, the researcher politely thanked them for making contact and explained that while their experiences of compassionate midwifery were extremely valid and interesting, they were outside the remit of this study. Apologies were offered because, in retrospect, the posters and leaflets could have made this more explicit. The posters
say ‘if you are pregnant or have had a baby in the last four weeks’ and failing to anticipate that partners may also identify with this was an error. These events also led to the researcher reviewing the aims of the research and reflecting on the justification for not including partners in the study sample. By returning to the methodological model in Figure 4-1 the researcher was able to justify this because key to this research process was the focus on women’s lived experience of compassionate midwifery. While a feminist theoretical lens did not, in itself, preclude the inclusion of the partner’s lived experience, it guided this study in making birthing women the priority and the experts in this. Understanding the partner’s lived experiences of compassionate midwifery required a different study.

The participant information pack contained details of the study, full explanation of what was involved, and participant consent form (see participant information and consent sheet in Appendix 12.3). Following this, if the potential participant agreed to be part of the study she confirmed this with the researcher by text message, phone call or email. She was then contacted by the researcher to make an appointment to interview her at home or in another place of her choosing. The researcher’s preference was for face-to-face interviews because these provided more opportunity to build trust, reduce misunderstandings and communicate authentically. However, alternatives (telephone or Skype interviews or providing written accounts) were available if face-to-face interviews were not convenient or acceptable to the potential participant. It was envisaged that some participants, particularly new parents with very young babies, would find these alternatives more suited to their needs. In the event these were not taken up and all interviews were face-to-face.

5.3.1 Sample Size
Phenomenological studies tend to use samples of between five and twenty (De Chesnay 2015:43). Those using IPA can be very small and tend to be fewer than ten (Smith, Flowers and Larkin 2009:52). Good quality IPA studies with fifteen participants or more have been published (Turner and Coyle 2000, Wood et al 2016). According to Smith and Osbourne (2015) there is not ‘right number’ and the decision on sample size should take into account practical and time constraints on the researcher. As the lead researcher undertook this study as part of a three year full-time doctoral project, there was an opportunity to study a comparatively large number of women, while staying true to the idiographic commitment that is fundamental to IPA. The size of the sample was based on a judgement about the time, energy and resources available and with this in
mind a sample of at approximately fifteen women was planned. Importantly, this provided scope for a range of different women with experiences of compassion from midwives (within both NHS Trusts) during the antenatal, intrapartum and postnatal periods. Although the recruitment strategy did not dictate quotas the researcher had scope to be purposive and ensure that some variety was achieved within the sample. This prevented a situation in which, for example, all data pertained to the intrapartum period as this would not reflect the range of midwives’ work. Moreover, the researcher wanted a big enough sample to facilitate saturation of data and achieve the study aims (Mason 2010). The final number of participants was seventeen. One participant contacted the researcher, and was interviewed, before and after the birth of her baby, therefore there were eighteen interviews in total.

5.3.2 Inclusion and Exclusion Criteria
Women suitable for recruitment to the study were required to have had recent experience of midwifery care that they considered to be compassionate. They were either pregnant and had experience of antenatal care from a midwife or midwives and/or they had had a baby within the last ten weeks and had experience of intrapartum or postnatal midwifery care. Those under sixteen were excluded as interviewing children under sixteen would have involved obtaining parental consent (Shaw, Brady and Davey 2011). Moreover, interviewing mothers under sixteen would have been outside the parameters of this study and would require a different study designed with this purpose in mind. Non-English speaking women were excluded as there was no funding allocated for face-to-face interpreting services. While the use of web-based and telephone translation services were considered, they were judged to be inadequate for an in-depth, personal and detailed interview.

5.4 Ethical Considerations and Approval
The principles of autonomy, beneficence and justice were considered in relation to all aspects of the study in preparation for submission of an ethics application as recommended by Orb, Eisenhauer and Wynaden (2001). Ethical approval was obtained from Coventry University (CU) Ethics and from the Health Research Authority (HRA) which approves all research taking place in the NHS. Autonomy is a person’s right to self-govern and act as an individual and it is protected through human rights and data protection law. In this study participants’ autonomy was respected through seeking fully informed consent. Written information about the study included details
about the researcher's position and background, supervisors' names and a short but clear explanation of the purpose and aims of the study. A question and answer format provided easy-to-read information covering all key points, as recommended by Groenewald (2004) and this was used to provide details of what was entailed. Participants were informed that their participation was voluntary and they could stop at any point. As part of the informed consent process participants were made aware that in the final report and in academic papers related to the research, their anonymised quotes from the interviews could be included. The process for ensuring anonymity and confidentiality of data was explained. After reading all the information and having a chance to ask questions a consent form was signed by each participant prior to the start of each interview (See Appendix 12.3).

In this study the principles of beneficence and non-maleficence guided efforts to reduce the risk of harm to both participants and researcher. Potential safety needs of participants and researcher were identified and outlined in Table 5-1 and Table 5-2 within this chapter.

5.4.1 Safety of Participants
Justice in research is about being fair to participants and never putting the aims of the study above the needs of participants. The Belmont Report (US Department of Health and Human Services 1978) provided influential guidance on the justice principle in research ethics and outlines the requirement to ensure reasonable, non-exploitative, and well-considered procedures which should be administered fairly. In this study these principles were reflected in an open, honest and transparent recruitment process in which women were not approached but chose to respond to a poster or leaflet. Attention to the researcher/participant relationship increased awareness of how power dynamics impact on both parties, have the potential to be exploitative and could potentially threaten the credibility of the study. The researcher used a variety of methods including interviewing in the woman's home (her own space) where possible and by ensuring each woman understood she had control over the interview in that she could stop it at any point and could stop the audio recorder. In addition, a feminist theoretical lens, personal reflection and journal notes were used to raise awareness around the researcher/participant relationship, identify and manage this potential risk and seek ways to minimise power imbalances and prevent exploitative behaviour or language and were explored in Section 4.7.3 of this thesis.
Issues around birth experiences may be upsetting for some women. Even though the interviews were with women who had a positive experience of compassionate midwifery, some also had negative experiences during the current, or a previous, pregnancy or birth. This could be regarding poor or uncompassionate care or distressing memories from a traumatic birth. Sometimes, during interviews, they served as a comparison with their experience of compassionate midwifery. Although not the prime intention of the interview, it was understandable in terms of participants setting their lived experience in context. The researcher was mindful that experiencing negative childbirth experiences might impact women’s mental health (Simpson and Catling 2016). There was also the potential for women to discuss details of their ongoing health concerns regarding themselves or their babies. Therefore to ensure that any concerns about the physical or psychological safety of participants or their babies were addressed, a protocol was developed with each Trust to signpost women to appropriate support if indicated (see Appendix 12.4). This included signposting to a supervisor of midwives, community midwife, general practitioner, health visitor, counselling service or the NHS Trust complaints procedure.
### Table 5-1 Identified Safety Needs of Participants

<table>
<thead>
<tr>
<th>Safety of Participants</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk of:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Feeling obliged or coerced to take part | • Potential participants not approached by researcher – women led recruitment  
|                         | • Potential participants text or email the researcher if they want information about the study  
|                         | • Information pack sent  
|                         | • Informed consent  
|                         | • Right to withdraw  
|                         | • Attention to power dynamic within researcher/participant relationship  |
| Feeling inconvenienced or uncomfortable | • Interview in own home or alternatives offered  
|                         | • Interview face-to-face or alternatives offered e.g. Skype/telephone/written  |
| Becoming distressed when remembering experiences around birth | • Empathic listening skills  
|                         | • Experienced midwife as researcher  
|                         | • Referral pathway to Birth Listening Service and Perinatal Psychology Team if required  |
| Health concerns or need for support (woman or baby) | • Introduce self in role as researcher to avoid confusion  
|                         | • Referral Pathway to community midwife, health visitor, GP, NHS Trust complaints procedure, Supervisor of Midwives if required  |

#### 5.4.2 Safety of Researcher

A dedicated research mobile phone was used for this study thus avoiding personal details being given out to participants. Interviews were undertaken in daytime hours and in women’s homes or another venue of the woman’s choice. The researcher complied with the Coventry University Lone Worker Policy and was mindful of ensuring that the immediate environment did not pose a safety risk. Before each interview another member of her team was informed where the researcher was going and when. Following the interview, telephone contact was made to confirm completion of the interview. In the event that this did not happen in a timely manner, the team member would attempt to make telephone contact with the researcher. If unable to do so appropriate and timely action would be taken to confirm the researcher’s safety.
Listening to women’s personal accounts of childbirth is sensitive and emotional work and may be emotionally demanding for the researcher (Dickson-Swift 2008). The opportunity to debrief was available throughout the study through links with an experienced researcher and supervisor. This was not required although participants did share upsetting information at times. Two of the participants had experienced late stillbirths in the past and these tragic events were important parts of their stories. The researcher’s experience in this area was invaluable when this happened. It became an opportunity to show the participant compassion, even amidst the studying of it.

### Table 5-2 Identified Safety Needs of Researcher

<table>
<thead>
<tr>
<th>Safety of Researcher Risk of:</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Threats to personal safety   | • Dedicated research phone  
|                              | • Interviews conducted in daytime hours  
|                              | • Checking-in with another team member before/after interview  
|                              | • Compliance with University Lone Worker Policy |
| Researcher upset/stress due to the emotional work associated with listening to birth stories | • Availability and access to debriefing if required |

#### 5.5 Data Collection: Interviewing Women

Interviewing women in feminist research was once considered a contradiction in terms and inconsistent with a feminist methodology, due to the problem of an unequal power relationship between the researcher and the researched (Oakley 1981). Clearly, many traditional hierarchical interview relationships are rooted in a patriarchal model and do not fit with a feminist approach. Yet interviews are used to good effect in feminist research (Devault 1990, Oakley 2016). The key concern is with the lack of reciprocity because the information (sought by the researcher for her own purposes) passes only one way, from researched to researcher. This demonstrates a power gap which is at least potentially exploitative. The counter-argument states that reciprocity can in fact be a feature of interviews with women if the right relationship is nurtured. To do this the
researcher must invest time and effort in establishing rapport, empathy and being a good listener. When this happens women seem genuinely enthusiastic to actively engage in the interview process (Oakley 2016, Finch 1988). Creating the opportunity for a social relationship between researcher and participant has been deemed appropriate in some situations, yet it is controversial because it may influence the way the research is framed and impact on how much the participant wishes to reveal (Hunter, S. 2005). Tang (2002) described how interviews with women are social encounters and interactive processes. A spirit of sisterhood is sometimes implied in feminist research interviewing with the notion of researchers drawing on their shared experiences as women (DeVault 1990). Yet it is a fine line, as if the research relationship becomes a friendship it might raise professional and ethical issues and impact on the quality of the research process. Therefore some boundaries need to be maintained (Drury, Francis and Chapman 2007). However, the researcher who develops a ‘friend’ persona may minimise the power relationship between researcher and participant and signal a connection through which there can be reciprocal dialogue and understanding in a positive atmosphere (Caven 2012). Certainly empathic, respectful connections between researcher and participants have been a strong feature of many feminist research studies collecting data through interviews with women (Cotterill 1992, Finch 1988, Hunter, S. 2005).

It is the context in which the interview is set and the ways in which the participants are involved that can make it feminist. An important example of how this can work is the notion of the interview as a ‘gift’ from the participant (Oakley 2016). When viewed this way, the participant (fully informed) is not passive but actively chooses to donate time, understanding and material to the study for personal or altruistic reasons. This is a clear example of how power relationships in interviews with women are not just one way and they are not purely concerned with social, personal and cultural differences like class, race and education. They are complex, fluctuating and deeply affected by the meaning given to the encounter. Therefore, there is a case for researchers not making simplistic assumptions about the power relationships with women participants but for being aware that they will be different with every woman and in every set of circumstances. When they are present, power discrepancies can be minimised through effective counterbalances and strategies. Forging respectful relationships with women is important, but so are techniques and interview styles that are less structured and more conversational than a traditional interview, enabling participants to have more control. In this way women are not merely providing answers to questions but they are
telling their unique stories, weaving their narratives in the way they choose to and at the same time allowing the interviewer to respond, seek clarification and develop deeper levels of understanding. This is why in this study minimally structured interviews with a conversational style were selected as a most appropriate form of data collection for hearing and understanding women’s stories about their lived experience of compassion from midwives. Whilst potentially problematic for the inexperienced, the researcher was an experienced community midwife, used to visiting women at home and establishing rapport with women and finding ways to quickly put them at their ease. Arguably, the role here was that of researcher and a different ‘guest’ but these skills were transferable and maximised by using an informal approach to the interview with the aim of creating a situation in which women felt comfortable to talk freely about their experiences, thoughts and feelings. While acknowledging that interviews are always contrived to some extent and therefore never entirely naturalistic, the aim was to facilitate a conversation which felt comfortable for women and as natural as possible.

5.5.1 Interview Design and Procedure

Face-to-face interviews were the desired method of data collection because they synchronise time and place. This means that they provide more opportunity (than telephone interviews for example) to build good interview ambience and create rapport (Opdenakker 2006). Establishing rapport was an important part of the interview process which served to set the interview within a context of respect and empathic connection. This forged the foundations for intimate and rewarding interviews with women about their experiences of compassionate midwifery. In addition, social cues like intonation, facial expression and body language, explicit in the face-to-face interview, were important as they helped to convey meaning, thus enriching and contextualising the data. However, the women in the study (who were either pregnant or had recently given birth) were given the options of telephone or Skype interviews if face-to-face was not convenient or if they just preferred this. However, in the event, no participants took up these options and all the interviews were face-to-face. In fact women participants seemed to enjoy the contact of the face-to-face interview. Most took place within the participant’s own homes, but two women were interviewed in private rooms within the hospital environment as they were in-patients at the time.

The researcher sought to ensure that each participant was fully informed about the purpose and the process of the research, including what would happen to the data collected at interview and how it would be stored and used. Each participant had
previously received a study information pack and consent form (see Appendix 12.3) and this was signed and collected prior to the start of each interview.

Many of the participants had new babies with them and prior to starting the interview a discussion took place in which the priority of the mother and baby's needs was acknowledged. All participants were reminded that they could stop the interview and the audio recorder at any point they wished and that it was expected that this would happen if the baby required attention, feeding, changing or for any other reason the participants wanted.

Minimal demographic data about age, nationality, parity and profession was collected. However, it was not the purpose of this study to achieve representativeness or relate demographics or any other variable to women’s experiences. The demographic details served only to situate the sample (Tuckett 2004).

The interview schedule was designed to elicit depth, breath and quality of data from the participants to address the research question and aims. Therefore, the interview was designed to facilitate full and rich descriptions from women participants (Baumbusch 2010). Although broadly semi-structured, the aim was to conduct the interview as a conversation as much as possible so that participants felt relaxed enough to tell their stories and the questions and discussion felt as natural as possible given that a research interview is fundamentally a contrived interaction and, as such, never truly naturalistic. To this aim pre-determined questions were kept to a minimum, providing opportunity to be flexible with the direction of the discussion and encouraging individual styles of storytelling (Doody and Noonan 2013).

Before the opening question the clip-on microphone was attached to the participant’s clothing or nearby and the audio recorder was turned on. The opening question was preceded by a discussion on how the participant had become aware of the study and if they had seen a study poster or leaflet. Then the opening question was:

‘In as much detail as possible can you tell me about the compassionate midwifery care that you have experienced?’

Importantly, the researcher made no attempt to describe or define what compassionate midwifery might be. This was explicitly left to the woman to decide. Therefore the implicit definition of compassionate midwifery for the purposes of this study was anything that the woman thought was compassionate midwifery.
Although the intention was to hear about positive experiences of compassion, sometimes participants wanted to talk about a negative experience of a midwife’s lack of compassion. Sometimes this was as a comparison to compassionate care but at other times it was just an experience that the participant wanted to include as part of their birth story. When this happened the participant was listened to empathically. However, the researcher was able to bring the conversation back to compassionate midwifery by asking:

’Can you tell me how that midwife could have been more compassionate with you?’

Other questions were used as appropriate, to encourage the participant to expand or qualify what they had said about compassionate midwifery care. These included questions like:

’Could you tell me more about that?’

’What was that like for you?’

’Is there anything else you would like to say related to that?’

Probes and prompts were used frequently and these helped to encourage the woman to reflect on what they had said or to explain in more depth or detail. Sometimes repetition of the woman’s last phrase was used as a technique to aid clarity and draw out the narrative. This technique is a useful method of encouraging more explanation and description of meaning (Leech 2002). The interview design allowed flexible use of appropriate open questions to facilitate the woman’s account of her experience of compassionate midwifery. These included (but were not limited to) the following questions which were used when the woman talked about the experience but omitted to provide detail or to describe their thoughts and feelings:

’What did you think about that?’

’Can you tell me how that made you feel?’

’What did that mean to you?’

’Can you explain a little more about why you found that compassionate?’

Sometimes probing questions and prompts took the participants by surprise as they were asked to look deeper into aspects of what they had said. For example some women participants were very confident and fluent when explaining about something
their midwife did that they thought was compassionate but could not automatically answer questions like:

'What did that mean to you?'

However, with time and encouragement to explore their thoughts and feelings around these events and sometimes going back to it later in the interview, they were able to consider their experiences in more depth and explore the meaning for them.

The last question asked was:

'Is there anything else that you can tell me about any compassionate midwifery care that you have experienced?'

Before leaving the participant selected a pseudonym. The rationale for this is discussed in more detail in Section 5.5.5. Another information sheet was provided so that if she remembered something later and wanted to provide further information she could request another interview or provide written information. The information sheet also recorded her chosen pseudonym and reminded her of what would happen to the interview data. She was invited to use the email address to request details of the study's progress and findings in due course. Finally, all women participants were given the opportunity to ask questions if they had any and were thanked for participating.

5.5.2 Pilot Interviews

Interviews with four women were undertaken initially to check the feasibility of the interview schedule and identify any logistical problems. This process increased the likelihood of a successful study as practical issues and any unforeseen problems with the data collection procedure could have been rectified in a timely manner (Perry 2001, van Teijlingen and Hundley 2002). Following this, discussion took place with the supervisory team to assess progress and reflect on the process. There were no particular difficulties and the interview schedule appeared to be working well. However, there had been some learning which helped inform future interviews. It was clear that although women participants had received study information prior to the interview they did not always read it thoroughly or remember it. Therefore it was both useful and ethically important to read it through with them and check understanding before they signed the consent form. Also because most women participants had very young babies with them (and sometimes an older child too) the interviews sometimes needed to stop for a while to attend to their needs and start again later. This was neither a
surprise nor a problem if sufficient time had been allocated so that participants and researcher could be completely relaxed about this. By learning from the initial interviews the researcher was better prepared for the remaining interviews. All four pilot interviews were completed and provided rich data which was utilised alongside the data from the remaining interviews. Although this might be criticised in quantitative research where it is more usual to set aside the data from pilot studies (van Teijlingen and Hundley 2002) it is not unusual in qualitative research. The pilot study in qualitative research is used primarily to iron out practical problems and gain experience and confidence in the process (Holloway 1997:121). Because no significant difficulties had been experienced there was growing confidence in the process and no reason to disregard the valuable data collected during these first four interviews.

5.5.3 Data Handling and Storage
Recordings were listened to in full to check quality and understanding, then transcribed verbatim into Word documents with three columns next to the text for annotation later. Transcriptions indicated (in bold type) any words that had been emphasised and included notes on non-verbal communication like laughing or gesturing as well as pauses. Transcription notation rules were used for consistency (Appendix 12.5). Audio records were deleted once the transcriptions had been made and read carefully to check that all words and meaning was clear. Transcriptions were kept on a password protected computer and backed up on a password protected USB stick which was securely stored in a locked cabinet.

Researcher field notes were kept in a journal to supplement and complement data from the women participants. This was kept in a locked cabinet. Journal notes included observations relating to participants, reflections on any aspect of the interview, evaluation of interview technique and details of any practical difficulties. A summary of the overall impressions of the interview was also created in the journal immediately after each interview and prior to listening to the audio recording. This provided useful additional data and assisted in contextualizing and developing the analysis (Smith, Flowers and Larkin 2009:73). All aspects of the journal played a part in enhancing reflexivity through openess and transparency and this assisted in making sense of the relationship between researcher, participants and the aims of the research (Lambert, Jomeen and McSherry 2010).
5.5.4 Reflexivity

Whilst field notes contributed to a rich description of the interview, a reflexive journal was kept to build on this through self-awareness, reflection and learning. Unlike the field notes, the reflexive journal continued beyond data collection, throughout the research process. This journal included reflection on how and what the women had communicated, as well as the researcher’s self-assessment of her role in the interview. Both field notes and the reflexive journal provided useful additional data which assisted in contextualizing and developing the analysis. Journal writing was consistent with feminist research theory and IPA methods (Biggerstaff and Thompson 2008, Gringeri, Wahab and Anderson-Nathe 2010, Smith, Flowers and Larkin 2009:73) and is recognised as a valuable tool when midwives step into a research role (Burns et al 2012). Qualitative research is a reflective and recursive process (Ely et al 1999:179). Reflexive journaling is an attempt to identify and work with the limitations of the research process. It is an ethically driven activity that acknowledges that the construction of knowledge takes place within a value-laden and subjective world (Guillemin and Gillam 2004). As such, it is a method in which the researcher attempts to understand herself in relation to the research and also how she impacts on the research. However, this is not a one-way process according to Malacrinda (2007), it is also a reflection on how the research impacts on the researcher. In this study all aspects of the journal played a part in enhancing reflexivity through openness and transparency and this assisted in making sense of the relationship between researcher, participants and the aims of the research (Lambert, Jomeen and McSherry 2010).

One of the ways that this assisted the researcher was in adapting to the researcher role. As an experienced midwife used to working with pregnant and new mothers and immersed in the subject of compassion, the researcher had concerns about being able to transition from midwife to the researcher role. Journal writing was a means of exploring and resolving some of the insider/outsider difficulties. These excerpts taken from the reflexivity journal relate to the first few interviews conducted:

‘……she was still not confident with breastfeeding and clearly a bit worried about it……….. it was a bit tricky to be a midwife but not be there to support her as a midwife’.

From reflexive journal 04/07/16

‘…at one point the baby was unsettled and I thought I knew why. As a community midwife I might have suggested something, but as a researcher that was not my place’.
From reflexive journal 04/07/16

‘. . . I must resist asking them things that are interesting to me as a midwife and stick to facilitating the interview to obtain the best and most relevant data’.

From reflexive journal 07/07/16

‘I am still learning how to be in these interviews’.

From reflexive journal 15/07/16

The above journal entries demonstrate the self-assessment and reflection that took place following the first few interviews when the researcher, who strongly identified with being a midwife, was adapting to the researcher role. Lack of experience and skills as a researcher and unfamiliarity in the role was identified and learning from this taken forward. Moreover, these entries demonstrate the experience of feeling part health care professional and part researcher or what Milligan (2014) calls an ‘inbetweener’.

The following journal entry, which relates to Participant 6, demonstrates how difficult this was when women were sharing their sadness with the researcher:

‘I am still learning how to get my role right in these interviews. I easily adopt an empathic listening role which seems appropriate but today’s interview was difficult because she got upset. Her pain was so raw and I was unsure of how to react in this new researcher role. I would not have been unsure as a midwife. I noticed that I was in danger of slipping into a counselling role at one point. I held back on this but asked her if she would like a break and checked that she was happy to continue. It was difficult because she was allowing herself to be vulnerable with me and she became tearful at one point. She said that she really wanted to contribute to the study because of her experience. Today I have seen how the boundaries between researcher and carer/counsellor can become blurred sometimes’.

From reflexive journal 15/07/16

After the first four interviews the researcher and her supervisory team reviewed the process. As part of this they considered what had gone well and what could be improved upon. Some of the journal entries were shared if relevant, including this one:
I have done four interviews now and all the women seem to be absolute experts on this subject. They have talked in detail about their experiences and they know why they thought it was compassionate and how it made them feel. Feeling justified in my decision to ask women what compassionate midwifery is.’

From reflexive journal 08/07/16

The above excerpt highlights the expertise of the women participants in the subject that was being researched: their experiences of compassionate midwifery. Interestingly this was in contrast to the previous entries which highlighted the researcher’s awareness of her lack of expertise. It was evident that there had been a shift in that researcher had become a novice and the women had become the experts. This also served to reassure the researcher that her belief that women who had received compassion from midwives would be the best people to explain what it was to them, appeared to be supported by the quality and quantity of the data from these women.

Following reflection on the benefits and disadvantages of this position (Brunero, Jeon and Foster 2015) the researcher recognised the importance of her midwifery skill set as an aid to understanding and 'tuning-in' to each participant but also the need to not step into a clinical role. She developed a technique of introducing herself to the participant before the start of each interview as evident in the journal entry below following a reflection on the interview with Participant 5:

‘When she let me into the house, she said to her young daughter: “….here is the midwife and we know what a midwife does don’t we?” The little girl said: “She helps mummy to have a baby” So I smiled and I recognised that although I loved being a midwife I was not here as a midwife. So I said: “Hello my name is (researcher’s name) and you are right, I am a midwife, but I am here today as a researcher. Is that Ok with you?” This seemed to be accepted well and I think it really set the scene. It also helped me to place myself in the interview. So I think it helped me most of all. I am going to say this at the start of every interview from now on.’

From reflexive journal 14/07/16

This entry demonstrates a way in which the researcher discovered a way to set out the position clearly for the participant which also helped her to positively identify with her role and purpose.

Despite the initial difficulties adapting to the role reflection enabled the researcher to learn and gain confidence in the researcher role. The following journal entry, written
after interviewing Participant 10 suggests some of the learning and development that had taken place:

‘I think I am getting better at this researcher role. I am not having so much trouble not being a midwife during the interviews. I find I can stand back and let the story pour out without interrupting. I am listening hard and trying to encourage deeper levels of exploration, not just about what happened, but how it made her feel’.

From reflexive journal 11/08/16

In this entry the researcher has clearly developed her skills in qualitative interviewing. It is an example of how the research process was not just having an impact on the women being interviewed it was changing the researcher.

The reflexive journal also assisted in dealing with dilemmas and methodological questions that arose during data collection. One such example is illustrated below:

‘Some women have talked about negative experiences and lack of compassion. This is usually as a comparison to compassionate care. Made me think about how this fits with an appreciative approach. I don’t want to ignore these parts of the interviews because I know they are important to the women. But in an appreciative approach, I am seeking accounts of what the experience of compassion is like, when it happens. I was able to talk to an experienced researcher who has used Appreciative Inquiry to study compassionate care in nursing settings. She gave me some useful advice. She said to listen to all parts of women’s stories, acknowledging the value in what they say. But she suggested ways of using their negative experience of lack of compassion, to get their views on compassion. For example using questions like: What would have changed that experience and made it more compassionate? What in particular, could that midwife have done to show more compassion? I have since tried this technique when women talk about negative experiences and it worked well. I didn’t even have to do it very much. Some women (like participant 8) did it automatically. They imagined and even ‘re-wrote’ what the midwife had done or said so that it was more compassionate. Some were very good at explaining exactly how, in their eyes, a midwife could have shown the compassion they needed’.

From reflexive journal 03/08/16

Although women in this study had been invited to talk about their experiences of compassion they sometimes compared and contrasted this with their experiences of lack of compassion. The above journal entry shows how initially this was a dilemma for the researcher. By reflecting on this and seeking advice from a researcher with more experience, she was able to find a way through this. By respecting and accepting
women’s negative stories and bringing the discussion back to the participant’s thoughts and feelings regarding what compassionate care is to her. This journal entry demonstrates how the researcher used the journal to reflect on what was happening in some of the interviews, identify a gap in her knowledge, seek to fill that knowledge gap, implement a change and evaluate that change.

The reflexive journal was used extensively during data collection but it was also used at times during data analysis and examples of entries that supported this process are included in Section 5.6. As with field notes, the reflexive journal was stored in a locked cabinet.

5.5.5 Using Pseudonyms

At the end of each interview the data was assigned to a pseudonym to support anonymity and confidentiality (Lahman et al. 2015). Women participants were asked to choose their own pseudonym as this actively involved them in the research process. The use of pseudonyms in research can be seen as a balancing act, complying with ethical and professional codes to protect the identity of participant’s data and balancing this with respect for the individual as an actual person and not just a number (American Psychological Association 2010:17). Encouraging participants to choose their own pseudonym provides them with a way of being honoured as an individual and having a say in how they are represented within any data relating to them included in the research outputs. Caution must be taken to ensure that the pseudonym is not too obvious and does not reveal the participant’s true identity or that of their wider family. With appropriate care this approach is a meaningful and nuanced act in which participants carefully and thoughtfully choose a name for themselves which has some meaning to them yet hides their true identity from others (Allen and Wiles 2016). It was of note that several participants in this study were initially reluctant and wanted their own names to be used as they did not see the necessity of hiding their identity. However, when the implications of this were explained, for example that other members of the family would also be identified by association, they agreed to choose a new identity for this purpose. In this study as in previous studies concerning pseudonyms (Allen and Willes 2016) the act of re-naming themselves and the ‘secretive’ sharing of this new name with the researcher seemed to cement the research partnership.
5.5.6 **Anonymity for Midwives and Others**

Although pseudonyms protected the anonymity of the participants, the midwives, partners and family member’s names, sometimes spontaneously used by the women in their accounts, were removed to protect their anonymity. Transcripts indicated their role or relationship to the woman, for example: [midwife’s name] or [partner’s name].

It is of note that not all of the midwives included in women’s accounts were female. Currently male midwives are in a tiny minority in the profession, representing approximately 0.5% of the workforce (Pendleton 2015). This makes male midwives easy to identify and presented a challenge when maintaining midwife anonymity. To this end, all midwives have been referred to as *she* or *her* in women’s quotes.

However, the reader should be aware of this and hold it in mind that throughout this thesis not all midwives were female.

5.6 **Data Analysis Using IPA**

Data analysis involved considerable reflexive activity as the researcher recognised the complexity of the process and the need to acknowledge pre-understandings and prejudices which might influence the interpretation of women’s narratives. The following reflexive diary entry illustrates the analytical dilemmas that were part of the process:

> ‘The problem as I see it is this: I have carried out a concept analysis on compassionate midwifery and produced a model of the concept. This has given me a way of thinking about compassionate midwifery which is grounded in the data and potentially useful when learning about this subject. It’s a problem because now I want to start again and understand women’s experiences of compassion from midwives. This required me to start afresh with an open, phenomenological approach. I have no intention of thinking about the concept analysis until I have finished the study, yet I know that I cannot get rid of my pre-understandings; I cannot put the genie back into the bottle! I am absolutely committed to analysing women’s interviews with a spirit of curiosity and discovery. I am genuinely fascinated to know what they think and how it is for them. I want to do justice to what they told me and want my interpretations to be true to what they say. The thing is, interpretive phenomenology (which underpins IPA) does not advocate ‘bracketing’ off experience or pre-understandings. Gadamer said that bracketing is impossible anyway (bracketing that is) because all understanding is interpretation. So even if I had not done the concept analysis I would always be interpreting what the women participant’s say in relation to everything else I have ever known or learnt. So as I continually open myself up to the possibilities of new discovery in this IPA study I have to keep reflecting...’
This journal entry highlights the researcher’s need to stay true to the openness and curiosity of phenomenology and yet be aware the inevitable pre-understandings and prejudices brought to the data analysis process (Spence 20117). By maintaining this reflexive conversation she was able to move through the IPA data analysis process which was both rigorous and challenging at times.

The Data from 18 interviews with 17 women provided a large quantity of rich data. IPA’s idiographic nature means that analysis proceeds on a case-by-case basis (Smith, Flowers and Larkin 2009:100). Each audio recording was listened to in full and then transcribed verbatim and audio files deleted. Member checking or respondent validation, the process of sending transcripts back to participants for checking and agreement, was not carried out. Proposed as a method of increasing internal validity (Lincoln and Guba 1985:236), member checking is often favoured in feminist research, as a means of increasing the participant’s control over the data. It was therefore seriously considered for this study. However, member checking runs the risk of participants self-consciously censoring and changing their transcripts beyond recognition. Goldblatt, Karnieli-Miller and Newmann (2010) point out that the activity can be very unpredictable and there is also potential to harm the participant/researcher relationship. Moreover, Koelsch (2013) has described how utilising the member check can blur the boundaries between therapy and research as participants reflect on their stories and enter into a prolonged relationship with the researcher. For these reasons it was not used for this study.

Each transcript was approached chronologically and treated as a case study in itself in which the focus was on the particular features and meanings within that case and without reference to any other case. It was only when all cases had been completed that emergent themes between and across cases were explored. A key difference between IPA and more traditional thematic analysis is this emphasis and focus on the particular prior to moving onto the shared. This also means that IPA is demanding in terms of time, effort, analytical and organisational skills. The first case proved to be particularly time consuming and accounted for three weeks’ work. The second took ten
days' work. However, the time invested in these initial cases paid off in that the following cases became relatively quicker to analyse. This was probably because the stages of the process were more familiar and the systems for recording and storing the analysis (set up during the first couple of cases) started to become established and easier to navigate.

Each individual interview transcript was analysed using the first seven steps of the eight-step process based on Smith, Flowers and Larkin's (2009) guidance and this is shown in Table 5-3 below. Their work has been pivotal to the development of IPA as in the last fifteen years although they have emphasised the flexibility of their approach which many researchers have used and adapted (Wagstaff et al 2014). However, Smith, Flowers and Larkin's (2009:79-101) guidance remains widely used and respected within the field. Step eight, looking for patterns across cases, only commenced once all the interviews had been analysed.
Table 5-3 Steps Followed For Data Analysis

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reading and re-reading the transcript and identifying key phrases and words.</td>
</tr>
<tr>
<td>2</td>
<td>Making descriptive/phenomenological notes.</td>
</tr>
<tr>
<td>3</td>
<td>Making analytical/interpretive notes.</td>
</tr>
<tr>
<td>4</td>
<td>Using notes to generate emergent themes</td>
</tr>
<tr>
<td>5</td>
<td>Organising themes into conceptual clusters or superordinate themes with similar meaning or connections using the following conceptual techniques: abstraction, subsumption, polarisation, contextualisation, numeration and function</td>
</tr>
<tr>
<td>6</td>
<td>Selecting appropriate quotes from the interview which illustrate the developed themes</td>
</tr>
<tr>
<td>7</td>
<td>Moving to the next case</td>
</tr>
<tr>
<td>8</td>
<td>Looking for patterns across cases</td>
</tr>
</tbody>
</table>

5.6.1 Reading and Re-Reading
This first step of the process required active engagement and immersion with the interview transcript. This was enhanced by deliberately slowing down to read the transcript line by line, thoroughly, and carefully. The purpose of this was to enhance understanding by really hearing the detail of what was said and attempting to enter into the participant’s world. The main challenge at this point was resisting the temptation to rush this stage by moving on too quickly, as ideas and conceptual links arose. Discipline was needed to limit notes to picking out important phrases and key words only and not going too deep too soon.

5.6.2 Making Descriptive/Phenomenological Notes
This stage involved making descriptive core comments in the first of two margins on the transcript. Staying close to the participant's intended meaning, the intention at this stage was primarily phenomenological in that it consisted of identifying and capturing what the woman participant said about her experience and what thoughts, feelings and
meanings she ascribed to it. The researcher’s challenge during this and the next stage was to not be superficial but do justice to this descriptive and phenomenological analysis yet to build the level of interpretation gradually, layer by layer, moving from the description of the participant’s meaning-making to the researcher’s interpretation of this. In this way, this stage and the next stage, in practice, formed a continuum rather than two separate stages, as the researcher started to use experience and knowledge to form a detailed understanding of the participant’s story to interpret it in different ways.

5.6.3 Making Analytical/Interpretive Notes

Using the second margin on the transcript for notes, this involved going beyond the women participant’s meaning-making and interpreting the data in a number of ways to complete the *double hermeneutic*. This represented the researcher’s meaning-making. Linguistic comments, for example the use of metaphors, repetition, emphasis or laughter were sometimes explicit and obviously complemented what was being said. At other times they seemed out of place or in contrast to what was being said and required deeper interpretation.

As the analysis took on a deeper interpretive quality the data was considered on a conceptual level, sometimes departing from the explicit narrative of the participant as the analysis shifted to the researcher's overarching understanding, drawing on appropriate theories and concepts. This is also when the process became most reflexive and when the analysis drew most deeply on the researcher’s knowledge, experience, thoughts and feelings. This acted as what Smith, Flowers and Larkin (2009:90) call a ‘touchstone’ which helps make sense of the participant’s account of her experience. However, this is always about using self to aid understanding of the participant and not vice versa. An example of the analytical process described here is shown below in Table 5-4.
Table 5-4 Example: a short extract from a transcript demonstrating the two levels of interpretation and initial emergent themes

<table>
<thead>
<tr>
<th>Transcribed from interview with Mary (pseudonym)</th>
<th>Descriptive/Phenomenological analysis</th>
<th>Interpretive analysis</th>
<th>Initial emergent themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘….I had a terrible day on day five, real baby blue, er, my milk had come in that day and I was just a hormonal mess really, erm, and she literally scooped me up, it was just lovely, she scooped me up and walked me to the side room and sat me down and just let me cry…..’</td>
<td>Having a terrible time on day five which she attributes to her milk coming in and the hormonal changes related to that. Emphasised the phrase: ‘Scooped me up’ and took her to a private space. Giving her time, space and permission to cry?</td>
<td>Describing her suffering (linked to physical and emotional changes in the postnatal period) Her suffering was recognised and responded to by the midwife who ‘Scooped’ her up and provided a protective space for her to express her upset in safety. Like a mother might scoop up a child to take to safety? ‘Scooped up’ describes therapeutic process of containing/holding (Jung 1946)</td>
<td>suffering vulnerability emotional recognition response privacy space (facilitating or holding a safe space) containing</td>
</tr>
</tbody>
</table>

5.6.4 Using Notes to Generate Emergent Themes
At this stage the addition of descriptive and analytical notes meant that the data set had increased considerably in size compared to the original transcript. This comprehensive data set was used in this stage of the analysis to develop the emergent
themes. The process of turning notes into themes involved physically breaking up the
different parts of the interview and using both the words spoken and the interpretations
to form similar or related clusters. These clusters or themes were named. It was usually
the case that there would be many initial themes, sometimes up to forty, particularly in
the first few cases. But this was due to a reluctance to leave anything out. It was also
due to using lots of different words with the same or slightly different meanings for what
was broadly the same sort of thing. However, by going back to the themes it was
possible to develop more concise and representative words, phrases or statements for
each theme. Therefore as progress was made through the cases the number of initial
emergent themes reduced to between ten and twenty-five per case.

5.6.5 Organising Themes into Conceptual Clusters or Superordinate Themes
This step involved mapping the links between emergent themes. It called for
conceptual reflection and innovation in organising and clustering emergent themes to
form a framework which conceptualised the meaning within the participant’s account of
their experience of compassionate midwifery. Abstraction is a technique which is
simply putting themes that are alike together under a more abstract name which
incorporates them all. Subsumption is where one emergent theme is recognised as
being superordinate as it can encompass other themes. For example, with anxiety, worry, concern and fear which could all come together as anxiety. Polarisation
examines themes for oppositional content to consider if they represent the same
theme. For example, banter and friendly chat and quiet and respectful might seem
almost opposite but could be considered together under level of verbal communication. Contextualisation relates to the individual participants story and in what context they
have framed or shaped it. For example, a number of different and seemingly
unconnected themes relating to the women participant’s experience might be linked by
context or temporal experience, such as safety or gratitude. Numeration identifies the
frequency of the theme and it is one way but certainly not the only way of deciding
which themes are most important. Emergent themes should also be explored in terms
of their function, for example it is possible for several different themes to have the
same overall function for the women participants.

Throughout this stage the researcher drew on background knowledge from midwifery.
Constantly holding the research question and aims in mind was essential.
Reconnecting with the original purpose ensured that themes were still relevant in some
way to this. Some themes were discarded if they did not. The remaining emergent
themes were organised into a smaller number of superordinate themes and a graphic representation produced.

5.6.6 Selecting Quotes to Illustrate the Developed Themes
Compiling transcript extracts is an important part of IPA analysis as it demonstrates internal consistency, scope and specificity of each emergent theme. This proved to be much more manageable and easier to track if done alongside the other stages rather than leaving it until last, as the step-by-step process might suggest. In practice the analysis up to this point was iterative rather than linear, although this was entirely consistent with descriptions of IPA method (Smith, Flowers and Larkin 2009). This made organisation even more important. Retrieving quotes from interview extracts became difficult almost immediately and the difficulty finding the exact parts of the transcript needed to demonstrate the generation of codes could have descended into a confusing puzzle and threatened the integrity of the whole process. At this stage a decision not to use software to organise data was seriously reconsidered by the researcher. However, by taking pains to keep organised every step of the way the situation was resolved. Records for each case analysis were transferred into a Word document with the appropriate quotes copied into an Excel spreadsheet. All quotes were organised by emergent themes and recording corresponding transcript line numbers became a successful method in terms of tracking and retrieval.

5.6.7 Moving to the Next Case
The process was repeated with each case. Each interview transcript was analysed as a separate case study. This same process was followed with every interview, prior to any analysis across cases. As analysis progressed through the cases the researcher also reflected on whether previous cases were influencing the codes generated. This has been discussed by other IPA researchers (Callary, Rathwell and Young 2015) who describe the difficulty forgetting previous codings. It was helpful to use the reflexivity journal to reflect on the question: Did these themes really emerge from this data only? In addition to this, independent checking by the three members of the researcher’s supervisory team provided further confirmation that themes were true to the data.

5.6.8 Looking for Patterns Across Cases
Analysis up until this point had been concerned with each case as a separate entity or case study. Once all cases were analysed in this way, the next stage was to look for patterns across and between cases. There are a number of possible methods used for
this. Smith, Flowers and Larkin (2009:84) advocate a manual method, spreading out hard copies of the theme lists or tables for each case on a large surface area. Others have described a process of going through each case to make one large spider diagram of emergent and superordinate themes. Researchers using specialised computer software like NVIVO and KMAX for earlier stages of analysis in other studies have reported some success, often using a mix of computer assisted and manual methods (Wagstaff et al 2014). Although this was considered, in this study a predominantly manual method was used. This provided an opportunity to get a comprehensive, visual overview of all the themes on a large display, with movable parts (flashcards and post-it notes) and take time to consider connections and relationships between themes and cases. From a practical perspective it meant that the master file of themes did not require opening up on a computer each time as it literally stayed in place for several weeks and analysis could stop and start seamlessly. Photographs of this process are in Appendix 12.6. At times this period of analysis was as a result of intense periods of work and at others it revealed itself after leaving it and coming back to it with new insights. Moreover, using this very visual and moveable system made it easy to see and discuss in meetings with the researcher and her academic supervisors. Agreement on themes and theme clusters was an important part of analytical quality and consistency.

Eventually a large master table similar to that described in Shinebourne and Smith's (2011) work was developed. This brought together data from all participants in the sample (on a spreadsheet) and demonstrated how themes were situated within superordinate themes. This master table linked themes to corresponding quotes, which detailed transcript names and line numbers, and captured the most important aspects of the analysis in one place.

5.7 Quality

Assessing the quality of qualitative research is fundamentally different to assessing quality in quantitative research. In quantitative research there are well established methods in place and these methods constitute a universally accepted discipline with a language of its own. Concepts like reliability, validity, transferability are well defined and utilised by all in this field as particular measures of quality (Chowdhury 2015). These concepts have little value in studies that don’t use the scientific method. Therefore, qualitative research requires a different approach and a quality assessment
framework which uses appropriate criteria. A number of methods have been proposed, however, Yardley’s (2000) criteria have been highlighted as particularly useful for IPA research because her criteria are broad ranging, provide a number of different ways of assessing quality and are suitable for many different study designs (Smith, Flowers and Larkin 2009:180-183). When attending to quality control in this study, Yardley’s four principles: sensitivity to context; commitment to rigour; transparency and coherence; and impact and importance have been considered.

5.8 Sensitivity to Context

Sensitivity to context commenced from the outset of the project with the selection of a topic area and the research aims and question which are concerned with the very personal experiences of women regarding their care from a midwife. Yardley (2000) points out that the need to apply sensitivity to the context also applies to the theory underpinning a study. This was achieved through thorough exploration and consideration of previous works that are concerned with compassion in midwifery and assessment of the current state of knowledge, as detailed in Chapter 3. These were used to guide and align this study.

Adopting IPA also related to sensitivity to context in that it focussed attention, from the outset, on the idiographic and the particular. Sensitivity when negotiating access to participants, establishing rapport and building trust with the women interviewed was the key to conducting respectful, authentic interviews which in turn yielded the rich data. This sensitivity continues through the data analysis. An example of this is the way that IPA requires the double hermeneutic which is making sense of the participants making sense of their experience and necessitating deep and reflective immersion in the participants narrative and the context in which it is spoken (Smith, Flowers and Larkin 2009).

5.9 Commitment to Rigour

Commitment to rigour was demonstrated through the thoroughness of the study with careful and consistent methodological process. This included the appropriateness of the sample size, quality of data collection and depth and breadth of analysis. In this study these features were addressed through additional methods which build in transparency and checking procedures (Yardley 2000). This included using the researcher’s journal notes to set the data in context. Detailed checking was also carried
out by one of the researcher supervisors who independently scrutinised different steps of the research process, including the quality of interview transcribing, the process used for analysis and robustness of findings in relation to the data. This necessitated a disciplined and methodical system of storing all data, and work related to the data, in a way that allowed for an audit of the process. This in itself is good research practice (Koch 2006) and independent checking of this ‘paper trail’ to assess whether the data handling process, analysis and findings were justified, demonstrated a commitment to methodological and analytical rigour. Two other supervisors also checked data analysis intermittently and were involved in the cross-case analysis for the whole sample when all emergent themes were clustered to form superordinate themes as described in Section 5.6.8.

In IPA research commitment to rigour must also be concerned with whether the analysis has been sufficiently interpretive (Smith 2011). During this study the researcher developed and honed the skills required to follow the steps of IPA, paying particular attention to the interpretive aspect of the work and how this is pushed deeper (Smith 2004). Academic discussions with other IPA researchers and attendance at a number of IPA training and development groups assisted in honing interpretive skills. The researcher attended the first International IPA Conference in Scotland in 2017 and was able to present a paper and a poster and obtain feedback from other researchers using the same methodology. Furthermore, it was an opportunity for the researcher to ask some very specific questions and receive answers from some of the most experienced IPA researchers in the world, who have been instrumental in developing this methodology. This in turn led to building confidence in the process and a deepened level of interpretation in this study.

5.10 Transparency and Coherence

Transparency and coherence in research refers to the clarity of the research process within the writing up (Yardley 2000). There must be enough detail to provide a complete, clear and credible picture of the research process and how the findings were arrived at. In this study findings have been backed up with examples from the data. Quotes from women have been used when appropriate to provide the reader with an understanding of how the data has led to the findings. Coherence is also concerned with the degree of fit between theory, research question and methods. In this study this has been explored and justification provided in Chapter 4 leading to the theoretical and
methodological model for the study in Figure 4-1. Using a feminist theoretical lens alongside interpretive phenomenological theory, an appreciative approach and IPA data analysis, the model has supported alignment throughout the study and has demonstrated a coherent approach.

Disclosure of other relevant aspects of the research process, for example the researcher’s subjective thoughts, opinions and experiences regarding the study (as documented in the researcher’s journal) demonstrated transparency through reflexivity.

5.10.1 Impact and Importance
The true test of impact and importance can only be assessed by the audience it was intended for (Yardley 2000). This study was conducted to explore women’s lived experience of compassionate midwifery and the rationale for it was discussed in Chapter 4. The intended audience includes academics, midwives and other maternity care professionals as well as women who receive maternity care. It is contentious to suggest that the findings from this study are generalisable in the normal sense of the word because the sample was homogeneous and the design idiographic and thus concerned with understanding the particular rather than the general. However, it can be argued that the findings have applicability. By identifying superordinate themes across cases the findings from IPA studies reveal the individual experience within the common experience and therefore can play a part in developing models and theories about the universal (Smith, Flowers and Larkin 2009). Moreover, ways in which the findings play a part in building a model of compassionate midwifery will be explored later in Section 7.4 of this thesis. The findings are important because they do provide a deep understanding of women's experience of compassion from midwives which will enhance the body of midwifery knowledge and provide 'food for thought' for all midwives. Individual practitioners will need to consider the relevance of the findings for their practice. Those who recruit and educate midwives and those who commission and lead maternity services can also benefit from this rare insight into women's experience of compassionate midwifery. Therefore, this study demonstrates impact on, and importance for the midwifery profession and ultimately for the women and families they care for.

5.11 Conclusion
This chapter developed the discussion in Chapter 4 on methodology and focussed on the study methods. This commenced with the setting and recruitment strategy and the
ethical considerations before moving on to describe the data collection methods and approach. The specific issues around interviewing women were explored with reference to the work of other feminist researchers. This influenced the choice of interview as a method and the design and approach for the interviews used in this study. Data handling, storage and analysis was critically discussed in detail with reference to the steps of IPA and finally quality issues were considered with reference to Yardley's (2000) framework. This chapter has explained all the groundwork and practicalities involved in designing and carrying out the study as well as the work of analysing the collected data. The next chapter will report on the findings from that analysis.
Chapter 6 Findings

This chapter should be read in conjunction with Table 6-2 which shows all superordinate and emergent themes across all women.

6.1 Introduction

This chapter presents the culminated findings across all women participants in this study. Firstly, brief demographic details of the participants are presented. The data analysis methods described in Section 5.6 produced 21 emergent themes which resulted in the six final themes presented in this chapter. These constituted five superordinate themes and one stand-alone emergent theme:

The superordinate themes:

- Theme One: Women’s Need for Compassion
- Theme Two: Being With Me
- Theme Three: Relationship
- Theme Four: Empowerment
- Theme Five: Balance

One emergent theme prevailed alone as an important theme in itself. Although linked to all superordinate themes it did not form an integral part of any one superordinate theme. Therefore it has been presented on its own, this was:

- Theme Six: Compassion Made a Difference

To diagrammatically represent the overall findings Table 6-2 shows all superordinate and emergent themes in relation to each woman participant. Furthermore, Figure 6-1 depicts these findings within a model which sets out the relationship between themes and emergent themes.

In this chapter themes are explored in turn using extracts from women’s interviews to illustrate and underpin the development of each theme. Both the general and the idiographic is acknowledged by illustrating common themes in relation to individual experiences and perspectives. Although findings have been presented in relation to each theme, women’s accounts were more ‘messy’ than this implies. Women’s experiences of compassion from midwives were sometimes multi-facetted and featured a variety of things that happened simultaneously. Although analysis necessitates some
fragmentation and focus on the parts of the whole, a woman’s experience is always a whole, integrated experience. Therefore although each separate theme has been used as a framework to aid understanding, the reader will see how, at times, individual women’s experiences represent complex combinations of themes.

6.2 The Women Participants

The 17 women participants interviewed generated 18 interview transcripts. One woman who was interviewed during her pregnancy, approached the researcher following her birth to be interviewed again. Demographic details of the 17 participants are shown in Table 6-1. Most were white British women (14/17); the others Irish, Canadian and Greek. All were in professional or semi-professional occupations with the exception of the youngest woman who was unemployed. There was a wide age range (20 to 43 years) and the median age was 33 years. Eight women were primigravid or primiparous and nine were multigravid or multiparous. The sample had sufficient homogeneity to be suitable for an IPA study in that they were all women living in The Midlands, UK who had identified themselves as having recently received compassionate midwifery care within the NHS system. In this way they represented a perspective, rather than a population.
<table>
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<th>Occupation</th>
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6.3 Theme One: Women’s Need for Compassion

The purpose of this section is to present the ways in which women described the contextual and situational details of their experiences of compassion from midwives. Almost all of the women participants (16/17) explicitly set the scene which led up to their compassionate care. This was spontaneous and not something specifically sought by the researcher’s questions. However, when asked about the compassion that they had identified in their own care, with only one exception, women set this in the context of their emotional and physical difficulties and needs at the time. Their words revealed the context in which compassion was demonstrated to them and indicated why they needed compassion at that time. Sometimes this was in detail and involved explaining the series of events that led up to this and included details of previous births or other key events in their lives. Other women briefly ‘dropped’ these issues into the conversation, however they still spoke of them in relation to their need for compassion. Only one woman (Lisa) did not refer directly to her physical and emotional needs and vulnerabilities around her childbirth experience. Although it was notable that she did not express a specific need for compassion, she had experienced a high risk pregnancy (twins), breastfeeding problems and significant neonatal health complications.

Most women’s narratives revealed a range of reasons why they wanted and appreciated compassionate care from midwives. These formed emergent themes which were grouped into six sub themes.

The six sub themes identified were:

- Vulnerability
- Physical Pain
- Emotional Pain
- Anxiety
- Problems and Complications
- Transition to Motherhood

Together these formed this superordinate theme: Women’s Need for Compassion. Each of these is discussed individually below although they often appeared in combination within women’s accounts.
6.3.1 Vulnerability

Vulnerability featured in participants stories about their experience during childbirth. Jess was explicit about this:

‘I think it [compassion] is incredibly necessary….. I think you’re so vulnerable, you’re so vulnerable as a woman in labour…..’

Jess 13 447-451

Jess’s words clearly express her sense of vulnerability during childbirth. Her words exemplified the feelings of other women who identified how vulnerable they felt at this time. Jess’s position is that compassion is necessary because of this inherent vulnerability ‘as a woman in labour’.

Jane’s words testify to the intensity and the nature of her vulnerability at this time:

‘Cos I was very, very vulnerable, that’s how I felt, very vulnerable and exposed…..’

Jane 14 139-140

Jane’s emphasis on feeling exposed could be interpreted as meaning exposed in terms of bodily exposure. Childbirth, by its nature, is an intimate and physical experience yet shared with midwives and others who may be strangers, therefore discomfort with physical exposure is relevant here. However, Jane had revealed to the researcher that she had been diagnosed with tocophobia, a pathological fear of childbirth. It seemed that Jane was not just referring to physical exposure. She was also talking about revealing herself as a person with psychological vulnerabilities. Similarly, Louise felt psychologically vulnerable as she approached birth:

‘I have always been aware that this was going to be a huge trigger point for me…..’

Louise 01 23-24

Louise, who had experienced mental health problems when younger, thought that childbirth was a potential catalyst for a re-emergence of these old problems. Because of this she felt pregnancy and birth were particularly vulnerable times for her.

Similarly, Jennifer’s vulnerability was evident in her interview. Jennifer spoke of how she felt her age and situation marked her out and made her a target of other’s disapproval:
Jennifer’s words express her experience of feeling judged and alone and how having support from a midwife, whom she considered to be compassionate, had helped her. Most of the women in this study explained not just how they needed a compassionate midwife because of their circumstances, but also how it helped them. The perceived benefits of compassion from midwives which appeared in all superordinate themes is reported in more detail in Section 6.8

6.3.2 Physical Pain

When asked about the compassion that they had experienced from midwives, seven women (Louise, Mary, Maree, Imogen, Katrin, Jess and Jennifer), included some discussion on their experience of being in pain. Not all accounts of pain were connected with labour pain. Maree was admitted to hospital with pain due to a kidney infection during her pregnancy and she explained how two midwives (a student midwife working with her midwife mentor) responded to her at this time.

‘….overnight when I was in so much pain there was a student midwife there and she was absolutely amazing and she er kept coming to check on me and she was saying ’I am so sorry you’re in so much pain you know I hate to see people in pain’ and I thought that’s interesting cos you’re a midwife and obviously you see it all the time…..’

Maree 05 31-35

Maree remembers being in pain but she also remembered the kindness and concern she received at this time. She seemed surprised or puzzled when the student midwife expressed how she did not like seeing people in pain. To Maree, a midwife who disliked seeing others in pain, represented a contradiction. She seemed puzzled by how a midwife, who hates to see people in pain, could manage to do her job. Yet her words appear to testify to the value she placed on this empathic sensitivity to her pain.

This sensitivity to women’s pain experience may have been different for women in labour, as it can be argued that for many women, pain is considered a feature of labour:
‘……it’s supposed to be the most painful thing that could ever happen…..’

*Maree 05 198-199*

When women did talk about being in pain during labour (or of their expectation of being in pain in labour) their need for a sensitive response from those in attendance was evident as Esme stated:

‘….. I think when you’re in pain you just need a bit more empathy……’

*Esme 16 162-163*

Maree expanded on this:

‘…..in the fourteen hours, sixty hours, sixty-five hours I had with my first labour, of pain….. you want people, to be surrounded by people that are around that are, seem genuinely a feeling of compassion and caring about your pain and trying to do stuff….’

*Maree 05 204-208*

Here Maree’s words point to the unpredictable nature of the length of a labour and the suggestion that a labour may go on-and-on. She identified her desire to be ‘surrounded’ by compassionate people when in pain. It is not clear how many people she envisages or how they would surround her but there is a sense of her being encircled or enveloped by compassionate attendants and this being comforting and helpful. She outlined the genuine feelings (‘compassion and caring about your pain’) and the actions (‘trying to do stuff’) that these attendants would ideally demonstrate. Maree’s words appear to support the idea that compassion is a combination of both feelings and actions (as discussed in the Concept Analysis in Chapter 3). Maree was pregnant with her second child when interviewed. She was speaking from a position of a woman who had been through a labour but also as a woman who was approaching labour. Her words reflect a knowingness about what she would need when going through the pain of labour.

In contrast to Maree’s description of the care needed when experiencing labour pain, Faith remembered not getting the care she needed during her first birth:
‘…..I just have some horrible memories of begging for pain relief and, as you do when you’re in labour and you’ve had no pain relief so far, and just being told “No”. But there was no explanation…..I think I was only an hour or two from giving birth but I didn’t know that and I begged for pain relief and I was just told “No” and that was it’.

Faith 15 320-324

Faith’s distress when recalling this situation was evident. Particularly when she described ‘begging for pain relief’ and then the coldness of being told ‘No’. Faith reflects that this experience may have been only an hour or two before giving birth but she did not realise this at the time. She did not know how much longer she would have to endure the pain. Faith went on to explain that it was this distressing lack of response to her need, had led to her feeling emotionally traumatised by her birth experience.

Women who discussed pain during labour or birth had different experiences of the interaction between their pain, their ideas about pain relief, and their midwife. The midwife’s role in helping women to navigate through pain is referred to in other sections of this chapter, particularly in relation to Section 6.4 Being With Me and Section 6.6 Empowerment.

Louise remembered the pain she experienced at the end of her labour:

‘…..I had an epidural and um after the epidural……. everything just changed, everything was just so much calmer and um yea it was a really pleasant…….. it was you know pain free……and there was other people in labour at the same time and I could hear them or obviously in a lot of distress and pain and I was ‘oh my god why aren’t these people having pain relief? Why aren’t they having an epidural?’ …..the new midwife was lovely and took over really seamlessly actually it wasn’t awkward in any way and she was really kind and stayed with me until the actual delivery and the actual delivery part it was quite difficult, it was a forceps delivery and it was quite painful, the epidural I don’t think worked at all in the end, so it was you know incredibly painful at the end…..’

Louise 01 117-121

When Louise had her epidural she felt pain-free and calm but she seemed concerned for other women in labour whom she could hear. Rightly or wrongly, she interpreted what she heard as their ‘distress and pain’. When women hear other women vocalise during labour it can be disturbing and even frightening for them. This appeared to have been the case with Louise. Louise seemed very thankful for her epidural and unable to understand why the other women in labour didn’t have one. However, the midwife who took over her care at the change of shift, was remembered for caring for Louise at the
most difficult and painful time in her labour. Louise’s words above suggests that she felt undisturbed by this change of carer who was ‘kind’ and provided one-to-one care through her experience of returning pain and an assisted birth using forceps. As Louise reflected on her pain at the time she recalled how the epidural anaesthesia, that she had been so comfortable with previously, had stopped working. She remembers that because of this it was ‘incredibly painful at the end’ and yet she also gave this as an example of her experience of compassionate care.

Clinical procedures and examinations during labour or to induce labour were also mentioned in relation to pain. Two women (Louise and Katrin) had painful experiences of vaginal examinations which they discussed in relation to the midwives. Katrin described a vaginal examination and insertion of a pessary to induce labour and the two midwives involved in this:

‘….. I gave the permission to the younger or the less experienced lady to do it first and er I think she kind of struggled because I was still a bit closed and then the other lady took over and that was very rushed and very kind of, it felt very much more painful and er done, you know it was "let’s do it" and its done [pause seems to be thinking] .....I was like in pain and she would keep on going. Maybe that is what she had to do…..but er as I said she was a little bit more experienced…..I was very uncomfortable and I said “something didn’t work right then!”…..there were two different ladies then, the younger midwife and the older, this is what I am trying to say. Sometimes the younger midwives, even though they are less experienced they are more compassionate this is what I felt.

Katrin 12 276-280, 507-513

Above, Katrin compares the less experienced midwife who seemed gentler in her examination to the more experienced midwife who successfully inserted the cervical pessary as part of her induction of labour. While the experienced midwife was successful in this procedure she did so in somewhat rushed and business-like manner which led to Katrin experiencing pain. There is a suggestion that while the experienced midwife just kept going (despite Katrin’s pain) the inexperienced midwife had been unable to insert the pessary because she was unwilling to cause pain. While the experienced midwife was more successful in carrying out the clinical procedure she was remembered by Katrin for the pain caused and her lack of compassion. She made sense of this by proposing her theory (based on her experience) that sometimes younger, less experienced midwives are more compassionate than experienced midwives.
6.3.3 Emotional Pain

Physical and emotional (or psychological) pain were sometimes closely connected, however, emotional pain was more evident than physical pain in women’s narratives. Thirteen women discussed their experience of compassion in the context of emotional pain or distress. There was a sense of emotional pain being more unexpected and difficult to deal with without compassionate support. Katrin’s words below capture something of the enormity of her psychological pain following her birth:

‘I thought after labour that’s it. The pain finishes here. That’s the biggest part and I didn’t realise really that actually the psychological part even afterwards it’s huge, it’s absolutely massive, cos I didn’t feel like myself’.

Katrin 12 365-367

Katrin’s words reveal the widely held assumption that pain is a physical entity and, in relation to childbirth, it stops once the baby is born. The physical pain was expected and time-limited, but the emotional pain was, to Katrin, the bigger and more significant problem. As she remembers experiencing this ‘massive’, ‘psychological part’ she remembers not feeling like herself. Her words here suggest that birth had changed her in ways that left her feeling very unsettled. Katrin was scene-setting in this quote. She was explaining her thoughts and feelings around her experience of care from a compassionate community midwife who had responded to her in this context.

As a group, the women in this study had experienced considerable emotional problems. Two women in the study (Jessica and Jovey) had experienced full-term stillbirths in previous pregnancies. One woman (Jane) had tocophobia (a pathological fear of childbirth) and two women (Louise and Faith) had Post Traumatic Stress Disorder (PTSD). Family and relationship problems were significant emotional triggers for other women. Women appeared to recognise that their previous emotional experiences meant that they had a need for compassionate care.

Faith explained how her care during her first birth had caused her psychological trauma:

‘….when I see the word compassion it does resonate with me because I had what I would call the opposite to that with my first son and it had a huge impact on me psychologically and it meant that I had to have erm, kind of counselling and er psychotherapy, er in the run up to the birth with [name of baby daughter]. Because I was so anxious about birth and I actually had er, if you looked at it on paper, with my son it was a, a good natural labour, it was fine, it was quite quick but emotionally and
psychologically it had such a negative impact on me cos of how I felt I was treated. So I had to have kind of therapy sessions to manage my anxiety around it. I was just left in the room then by myself, with my husband for what was, seemed like forever, whereas all, I just keep thinking back to that moment and if all she’d have done was said ‘You’re doing really well, you’re gonna have a baby in the next couple of hours, just keep going, we can get through this’. Just a little bit of just motivation or something, I would have come out of that feeling like it was a good experience and I’d achieved something that was really difficult but I got through it. Whereas I look back and it’s just trauma to me cos it’s just begging for help and receiving none.’

Faith 15 18-29

Faith saw that her traumatic reaction to her first birth was as a direct result of a lack of compassion from her midwife at that time. With the birth of her daughter (her second birth), she was very happy with the compassionate care she received and this, and the effect it had on her, is discussed in other sections of this chapter. It was her very different experiences with her two births that she gave as the reason for wanting to be involved in this study. But her words above indicated the psychological pain related to her need for compassion not being met.

Other women disclosed emotionally painful events around the time of their pregnancies/births including relationship problems and a family bereavement. In addition, eight women described feeling emotionally unstable or emotionally distressed due to being ‘hormonal’ and/or overtired. This experience of feeling hormonal was always expressed with the suggestion of emotional turmoil or unease:

‘I was just a hormonal mess really’

Mary 04 129

Mary’s words were similar to others on this subject who drew comparisons between their emotions and a messy, chaotic situation in which they felt themselves to be in a state of disarray. Women recognised this as a time when compassion was valuable. Jess’s words illustrate this:

‘…your hormones are all over the place and your emotions are all over the place and I’m quite an emotional person anyway so it could easily have floored me and really affected how I experienced the whole thing, but erm no it was very good……little things people can say can have such a big impact

Jess 13 483-487
It seemed that for Jess, hormones and emotions were interconnected and both were ‘all over the place’ suggesting a situation for her which could have had a negative effect on how ‘the whole thing’ went. Jess recognised that ‘little things’ said by carers at this time which appeared to have a protective influence and protected her from being overwhelmed or ‘floored’ by this experience.

The ability to share concerns and confide in a midwife also proved valuable when women were experiencing emotional pain. Jennifer explained this:

‘I had like a ‘to-do’ with [name of baby]’s dad. So it was sort of like I was a bit down-in-the-dumps with that and having no one really to turn to, that was difficult but then having [midwife’s name] there and being able to open-up to her and speak to her about things made my life a lot easier....’

Jennifer 17 200-205

Jennifer, a single mother and the youngest woman in the study talked about her compassionate midwife who had supported her through her relationship problems. Jennifer’s words suggested a sadness and loneliness at the time. She seemed to lack emotional support with ‘no one really to turn to’. She was able to open-up to her midwife with whom she had a trusting relationship and she recalled how much this had helped her. The role of woman/midwife relationships in women’s accounts of compassion is presented in Section 6.5 of this chapter. Jennifer’s words above illustrated her particular reasons for needing a compassionate relationship with her midwife.

6.3.4 Anxiety

There was a sense of anxiety being a big part of the childbirth experience for the majority of women in the study. Twelve women talked about their compassionate midwifery in relation to their anxiety and this made it the most common context for the women in the study. Anxiety was not easy to separate from other emergent themes as it was as a feature of many of the other contextual details provided by the women participants. For example, complications with the pregnancy or with the baby also involved anxiety.

Anxiety is related to emotional pain but it is not the same. Emotional pain includes a range of emotions such as sadness, grief, regret and shame. It often relates to how something that has already happened affects a person’s present emotional state. In
contrast, anxiety is an uneasy concern or fear about what is happening or what could happen in the future. Women’s narratives showed a link between emotional pain from past experiences causing raised anxiety about the present or the future. Jovey’s anxiety in her current pregnancy was linked to her emotional pain due to her past experience of having a stillborn baby:

‘I think erm I think the difference is er that this would always have been, any pregnancy would have been a tough process, cos its nine months long and there’s a million things you can worry about erm but I think er I guess when I started worrying, rather than sitting and worrying about it on my own, because of the way [midwife’s name] is, I have always felt like I can just contact her and ask her and she would give me reassurance if that was appropriate or she would do whatever needed to be done erm and I think because of that its been easier to keep my anxiety levels to er what might be a more normal degree of anxiety, a manageable level erm and because I guess because I feel supported.’

Jovey 06 98-109

Jovey’s past experience induced much anxiety about her present and future. Her words provide an impression of the many opportunities for anxiety and how every minute and every hour of those long ‘nine months’ would provide the potential for anxiety. She recognised the inevitability of her anxiety with ‘a million things’ to worry about, specifically because of what she had been through previously. Jovey identified the difference that her compassionate midwife made by being somebody whom she could contact and share her anxieties with, and it was this that kept her anxiety levels ‘manageable’.

Women’s past experiences impacted on their anxiety and their need for a compassionate response to their anxiety. Maree had been affected by her sister’s traumatic birth and this played on her mind when she was in labour. Stories about birth and what to expect were a feature of anxiety for Helen. Helen had heard stories from friends and acquaintances about the postnatal ward which led her to be particularly anxious about this aspect of her time in hospital. Helen’s words expressed the power that other people’s stories had on her anxiety:

‘…..from what other people had said they’d said ‘oh yeah they just kind of leave you to get on with it and they tell you that you’ve just got to just deal with it cos you’re going home’ So you’ve got to get on with having a baby and working out what’s wrong with them. So that made me feel really nervous before, I felt quite anxious about, more probably after the birth and that if I had it later, had the baby later on at night that my
husband would then have to go and I would be left with a baby and I
would be expected to know what to do….’

Helen 09 126-129

Helen’s fears turned out to be unfounded and she was very relieved and happy with the
level of care and attention she did receive on the postnatal ward. However, her
trepidation regarding a lack of support on the postnatal ward and her fear that she
would be expected to ‘deal with it’ seemed to be a significant factor in defining her
particular need for compassion.

Some women disclosed that they had a tendency to worry or that they had a history of
anxiety. This took on an extreme form for Jane who had been diagnosed with
tocophobia. She summarised her fear around childbirth and the difference her care
made:

‘…..the actual birth just filled me with absolute terror…..I was so terrified
by the first experience, but after this one I would have another one
tomorrow. I think that is ninety per cent down to the care I received…..’

Jane 14 76-78

Jane’s anxieties, which had been so effectively addressed through her compassionate
care, were just concerned with the actual birth. In contrast, Louise had suffered with
anxiety from an early age:

‘I have suffered with anxiety in the past……when I was
younger……since then I have had the odd problem with anxiety and
panic attacks and things like that and I have always managed to control
it myself……my worst case scenario is not being in control, not knowing
what’s going to happen, not being in control of the situation and this was
the ultimate thing for me.

Louise 01 18-27

Louise’s words testify to her history of anxiety and her particular fear of feeling out of
control and yet she seemed aware that childbirth is not completely controllable. Within
her interview it was the ways in which midwives helped Louise to feel more in control
(and thus reduce her anxiety) that she found compassionate. Women’s experiences of
being supported to retain control are also presented in Section 6.6 of this chapter.

Over-and-above the different ways that women explained and made sense of their
anxiety, there was a general feeling that childbirth was innately worrying in itself and
that a certain level of anxiety was normal. As Imogen stated:
‘It’s a very scary time…..’

*Imogen 10 493*

For women in this study childbirth was a scary time for many reasons and when they described and made sense of the compassionate care they had received it was often in the context of their anxiety and the way that the midwife recognised and responded to their anxiety. There are examples of this throughout all sections of this chapter.

### 6.3.5 Problems and Complications

There was a sense of compassion being a much needed response from midwives when things were not going to plan or deviated from what women had envisaged. Nine women talked about complications or health problems concerning either themselves or their babies. For Katrin it was at such times that compassionate care made all the difference:

> ‘Where I feel er there was a difference made was when things were going badly…… two or three days after giving birth er I had to go back to the hospital……..psychologically that was a big turmoil for me er it was a difficult time’.

*Katrin 12 120-125*

Katrin’s words denote a clear link, for her, between times when ‘things were going badly’ and psychological difficulty. At such times compassionate care made a big difference.

‘Things not going to plan’ were associated with a number of emotions by other women. Anxiety and emotional pain were linked to this issue, alongside disappointment. Disappointment that things had not gone as expected or desired was discussed by five participants (Matilda, Mary, Imogen, May, Katrin) and appeared to be difficult to deal with. Acknowledgment of women’s disappointment was considered to be a compassionate response which helped women with it. Matilda referred several times to her compassionate midwife’s response to Matilda’s disappointment:

> ‘…..seeing why you would be disappointed about something and in some ways kind of having a bit of that disappointment with you…..’

*Matilda 03 93-95*

> ‘I just think as part of her caring role she was disappointed as well.’

*Matilda 03 39-40*
There was recognition that there was more need for compassion when there were obstetric or medical complications. Maree talked about there being more ‘need’ for compassion when complications arose during her birth which she had hoped would progress normally and without interventions.

‘The midwife that took over for the second shift em probably had more of a need to be compassionate or more of a compassionate role because…..I’d been in labour for a very long time and done really well with no pain relief then we had had to have lots of medical intervention just after shift change…..’

Maree 04 126-133

This quote seems to indicate that in Maree’s opinion there was less potential for compassionate midwifery during a straightforward birth. However, when birth does not progress in a straightforward way and things happen that were not envisaged or wanted, the midwife’s role needed to incorporate more compassion.

Louise also talked about her kind midwives in the context of her health complications during labour:

‘I was struggling with the diabetes and my blood sugars and things like that and there were ketones is it? In my urine and they were trying to get me to eat but because of the pain I was feeling sick and they were all kind…..’

Louise 01 117-120

Louise’s words underline the significance of her ‘struggling’ with unstable blood sugar levels while in the throes of labour. It seems that the mixture of clinical care and kindness of the midwives at this time was valued. There is a sense that it was because she had these extra complications that kindness was so appreciated.

6.3.6 Transition to Motherhood

Adaptation to life with a new baby, particularly for first-time mothers, emerged as a difficult time for some women. Fifteen of the eighteen interviews were with women who had new babies between 2-10 weeks old. It was evident that the process of adaptation was ongoing. Ten women discussed the compassion they received or needed in relation to their adaptation to mothering role and its impact on their lives. Below Katrin’s words capture the enormity of this change in her life:

‘….the dynamics are changing and I think that is something that we are not prepared for you know, you don’t really realise that a little seed is
Katrin expressed how ill-prepared she was for this change in the dynamics. She talked of the baby as a *little seed* perhaps referring to the conception. There was on the one hand a sense of the miracle of birth in which a new human being had been grown inside her from a tiny egg and sperm. There was also a sense of the chaos that a little baby had brought to her life and to those around her. What would it be like to be in an upside-down house? Although it might be taken on face value as a figure-of-speech it is worth delving into the language. With the house ‘upside down’ things don’t look the same. Everything has to be seen from a new perspective and what was familiar becomes unfamiliar. The metaphor of an upside-down house also suggests that everything falls out of its usual place creating a confused mess. Katrin was unprepared for the life-changes and upheaval which accompanied the birth of her first baby and her description illustrated a sense of emotional chaos in her new world. She saw the effect on the people around her, the relationships she has with them and how this had a knock-on effect on her sense of who she was. The household was changed and people were acting differently and unpredictably (‘dancing around’) and with this her very identity and sense of self was threatened (‘we forget who we are’).

Similarly, Beryl spoke of her shock at the impact of becoming a new mother:

‘…..I’d never been around a baby…..I was a rabbit in the headlights’

*Beryl 08 271-272*

‘…..you don’t know what you’re doing…..’

*Beryl 08 143*

Katrin and Beryl were the two oldest women (40 and 43 years respectively) and both had recently had their first babies. They both talked openly about feeling unprepared and alarmed in their new roles. However, younger women, like Imogen, also felt this:

‘…..this new born bundle of joy that you don’t have a clue what to do with.’

*Imogen 10 300-301*

Imogen’s words portray something of the expectation that the arrival of the baby is considered a joyous event and yet the reality is that it is accompanied by feelings of
inadequacy and uncertainty. It seemed that these feelings were the context in which some women needed compassionate care.

Compassionate midwifery care was discussed frequently in relation to breastfeeding issues. These seemed to represent considerable need in women for compassion from midwives. This was particularly the case (although not exclusively) for first time mothers. Nine women discussed feeding in relation to compassion from midwives. Some of these could be seen as complications or health problems but they were more often discussed by women in relation to their difficulties in the postnatal period and adapting to life with a new baby. Women’s stories about their difficulties with breastfeeding contained a sense of them being upset and anxious about the baby’s health and well-being and also anxious about ‘getting it right’. This pressure to do the ‘right’ thing was also a feature in other aspects of pregnancy, birth and caring for their new born babies. This pressure was experienced as coming from midwives and maternity staff but also from family and society in general. Jessica referred to this:

‘…..there’s all this hype around how important it is to do it right, and erm, from books from TV and radio…..’

Jessica 07 87-89

May had also been concerned about doing the ‘right’ thing:

‘…..you’ve not done this before, you’re like suddenly you’ve got this [baby] and you’re sleep deprived, you don’t really know, you don’t know if you’re doing the right thing….’

May 11.2 344-346

May’s words tell of the physical and emotional toll of life with a new baby alongside her fear of doing something wrong.

Mary spoke of her difficulties establishing breastfeeding:

‘…..I was struggling with breastfeeding I think it was the seventy-two hour check so she was only three days old, em, and yeah she was very warm and very compassionate and very understanding about where I was sitting as a first time mum…..’

Mary 04 115-117
Mary talked of ‘struggling’ with breastfeeding and receiving compassionate care from a midwife in this context. For Mary an important aspect of the midwife’s support was that she understood the nature of Mary’s struggle.

Four women (Louise, Maree, Helen, Katrin) discussed their experience of their babies having excessive weight loss in the early postnatal period and their distress linked to this. It is normal for new-born babies to lose some weight in the days following birth as feeding is established. Midwives screen babies for weight loss over 10-12% of the birth weight, as this may indicate a feeding or other health related problem. For Louise, Maree, Helen and Katrin this was an experience that seemed to represent a ‘perfect storm’ of pain (physical and emotional), anxiety, and a difficult transition to motherhood. Maree’s words indicate what an upsetting time it was for her:

‘…I wasn’t taking care of my baby because I wasn’t you know er I thought I was breastfeeding her and er I wasn’t - I was in absolute bits…..’

Maree 05 67-68

Maree’s words are an example of the feelings caused by this revelation that her baby, who she thought was successfully breastfeeding, was not ‘thriving’. The distress in her voice was audible as she explained how she felt that she was not ‘taking care of’ her own baby. Maree’s words illustrate how inadequate she felt at this time. There appeared to be an urgent need for compassionate support in this situation. Maree went on to describe the lack of compassion she received from one midwife, followed by a more compassionate approach from another. Similarly, Helen explained her feelings when her baby was losing weight:

‘….when we came home and they said “right he’s losing weight”…..I felt I wasn’t doing a very good job because I wasn’t producing enough milk…..’

Helen 09 222-224

Helen’s feelings of inadequacy in her role were evident in her words. Such feelings may be common. Women’s experience of breastfeeding problems has been the subject of studies elsewhere and it was not within the remit of this study to explore these in any detail. However, women’s thoughts and feelings about themselves and what they needed from midwives at this time come through powerfully in their stories. For Helen
it was these feelings that made compassion so relevant. She reflected on how important it was for her at this time and why she came forward to be in this study:

‘I think it [compassion] is important, that’s why I have taken part in this research. I just think, especially with a first child you want to feel that there’s somebody else there and they’re kind of sort of on your side and looking out for you as well and giving you the support that you need and I felt that I really, really received that.’

Helen 09 204-207

Women gave many examples of compassionate midwifery care when they experienced difficulties with feeding and other aspects of life with a new baby. Some of these experiences will be explored in the other sections of this chapter in order to illustrate the ways in which women recognised, described and made sense of compassion from midwives at this time.

6.4 Theme Two: Being With Me

The name of this theme: ‘Being With Me’ was chosen to reflect the many different ways a midwife acted towards women when they experienced compassionate midwifery care. It represents a range of experiences from most women in this study (16/17), which collectively highlighted the feeling that there was something about the way that the midwife was with the woman that was an important part of compassion. It encompassed three emergent themes across all women:

- Calm and Relaxed
- Communication and Touch
- Available and Tuned-in to Me

The superordinate theme: Being With Me is explored below by focusing on each of the above themes in turn.

6.4.1 Calm and Relaxed Approach

The midwife’s calm and relaxed approach, and an ability to help women feel calmer, was a common emergent theme. Eleven women: Louise, Lisa, Jessica, Helen, Imogen, May, Katrin, Jess, Faith, Esme and Jennifer talked about this as a feature of their experience of compassionate midwifery. Women explicitly noticed whether midwives had a calming manner and a calming voice:
‘….it was very encouraging to hear her voice and she was very calm and very, very supportive’.

Katrin 12 296-298

Katrin focussed on her midwife’s calming voice whereas Helen described the whole ‘attitude’ of the two midwives who cared for her in labour:

‘….their attitude…..they’re very laid back so it didn’t make you feel stressed at all…..they were both very calm and just relaxed with me which made me relax….. cos for me I’m quite a stressful person so for them to be calm with me helps me to calm down. To think “no it is OK and they’re here and they’re relaxed, I can just relax everything is Ok, it’ll be alright” so that was really helpful for me.

Helen 09 86-105

Helen’s experience was that because the midwives were calm and relaxed, she felt she could relax. She recognised that she was ‘quite a stressful person’ but that their attitude was a factor in soothing her and controlling her stress levels. In her mind their relaxed attitude signalled that everything was ‘OK’, and if that was the case, then she could relax too.

Privacy and a quiet and calm environment were important, particularly for women in labour and also for women who were anxious or distressed. May talked about how compassionate midwives helped her to calm down when she was admitted to hospital at thirty-five weeks gestation with raised blood pressure. During the interview May recalled how distraught she had felt at this time:

‘Well Friday obviously I was downstairs having my blood pressure taken, somebody bought me up and I was already a mess because I’d only expected to come in and have my blood pressure taken and be sent home and then I knew that I had such a busy weekend ahead of me. I’d got a wedding and it was my wedding anniversary on the Sunday as well and to think I was being kept in hospital was just so upsetting, I was in an absolute mess and they bought me up into the labour suite…… the first thing she was, she was like “I’m not going to take your blood pressure now, would you like a cup of tea?” and it was that sort of, she just made me a cup of tea, calmed me down and it was that sort of thing and I was just like, it, I felt like, I was kind of at home. It was almost like comfort……….. It’s the smallest thing’.

May 11.1 40-59

During the interview there was a sense of May feeling very busy with her own meaningful and much-looked-forward-to social arrangements. These arrangements
had clashed with her maternity care which had suddenly taken precedence and become urgent. She was clearly upset and disappointed by this unexpected turn of events. Her plans and her emotions were in turmoil or in her words in ‘an absolute ‘mess’. Yet on Labour Suite the first thing that the midwife did was to offer her a cup of tea. May explains the impact of this on her. It was ‘the smallest thing’ but it had a big effect in calming her down because she saw it as a symbol of home and comfort. Offering and making tea was a feature of other women’s experiences and crossed other themes. It will be discussed in relation to Theme Five in Section 6.7.1 of this chapter.

May’s blood pressure was very high, she had pre-eclampsia (a serious pregnancy complication) and she required urgent intervention:

‘…..well the first lady that saw us was the lady who put my cannulas and catheter in and the first thing she did was put some relaxing music on in the background, she just put her phone on and put some relaxing music on and turned all the lights down and it was just that sort of ‘right we’ll calm you down, let’s get you nice and calm’ [May demonstrates a calming tone of voice when relaying the midwife’s words] cos they knew my blood pressure was sky high and obviously the reason I was there was pre-eclampsia but it was just that like, I don’t know just trying to put you at ease straight away…..’

May 11.1 52-58

The midwife needed to carry out invasive clinical procedures, for example gaining intravenous access and inserting a urinary catheter into her bladder. As before, when she was offered tea, May was both surprised and grateful that the first thing the midwife did was not anything clinical but just to help her calm down, this time by creating a calm environment for her. She used music and lighting, as well as her own voice and approach, to create a calming space which worked well to put May ‘at ease’.

6.4.2 Communication and Touch
In section 6.4.1 women’s initial contact with a midwife was important and if the midwife’s approach was seen as compassionate it seemed to set the scene for their ongoing care. Similarly, compassionate communication seemed to very quickly identify midwives as compassionate. Forms of communication highlighted in women’s interviews were both spoken and non-verbal, and included listening. Beryl’s words below indicate just how quickly communication can have an effect:
For Beryl just a couple of sentences is all it took, and the nature of midwives first few words with women was noted by others. Louise, Lisa, Jess and Faith highlighted the positive impact of good introductions. In contrast, Imogen had an experience with a midwife on the postnatal ward whom she thought was not compassionate. Imogen felt that a proper introduction would have made a difference to her experience:

‘….. It’s such a small thing at the start, I think if that midwife had come to me and said….. ‘Hi my name’s so-and-so I’m going to be here to help you. I’ve had the handover notes, this is what I’ve noted from it. Is there anything that you want to go through, anything else?’ and just acknowledge that you’re not just a piece of paper going through the system…’

Imogen 10 348-356

In this part of the interview Imogen scripted the introduction that she would like the midwife to have used. She was putting herself in the midwife’s place and acting out her part to demonstrate what she knew would have made a difference to her. This imagined speech consisted of a simple introduction and an explanation of her role and current knowledge of her needs. It also served to establish a partnership approach to her care by inviting her to express her needs: ‘is there anything you want to go through, anything else?’ It acknowledged Imogen as an individual as opposed to a ‘piece of paper going through the system’. When Imogen uses this analogy it suggests that her encounter with the midwife on the postnatal ward left her feeling like a thing such as a document or a statistic, (rather than a person) passing through the ‘system’ of maternity care. There was the implication of impersonal, institutionalised care in which she felt processed rather than cared for. This is a subject which was raised by other women and it is discussed further in Section 6.7.3 of this chapter.

An introduction was an important aspect of Faith’s experience of compassionate midwifery when she was in labour having her second child. She had experienced Post Traumatic Stress Disorder (PTSD) following her first birth and felt anxious and vulnerable going into labour again. She describes how her midwife was with her in labour, as highlighted:

‘……if you could write a job description of a compassionate midwife it would just be her…….. first of all, and it’s such a basic thing, she
actually introduced herself to us. She said, you know, “I'm [Midwife’s Name] and I'm gonna look after you” and that didn’t happen the first time and I just thought Oh! So it was kind of like she acknowledged us and started a relationship with us........'

Faith 15 98-109

This extract indicates that Faith understood that, in theory, an introduction is ‘such a basic thing’ and yet it is clear in the interview that it had a profound effect on her. The simple act of giving her name and outlining her intentions “I'm gonna look after you” was a brief, straightforward interaction and yet a very powerful one for Faith as it was not something that happened in her first labour, and in her first labour she did not feel looked after. She had previously disclosed how the prospect of that happening again was very frightening for her. The simple acknowledgement of her as a person in need of care and her role as her carer was compassionate and hugely reassuring to her.

She goes on to describe how her midwife was attentive and sensitive to her as she carried out various aspects of her care:

‘....if she ever examined me or she ever kind of touched me to put er, listen to the heartbeat or anything she’d always just say “Is that comfortable? Are you OK?” and always just making sure I wasn’t in any physical discomfort because of what she was doing, which I never was anyway but she asked, she was aware and she just read through my birth plan and she kind of really took it in and asked a few questions about it so she was actually looking at what we liked and she just made a bit of conversation with us. But one of the things that she did that struck me as really good and again it’s a basic thing, was she’d be doing some paper work and then I might ask her a question and even if it was just to make conversation and she’d just come away from the desk area and come round and talk to me and look at me and just take that time’.

Faith 15 98-109

Above, Faith described the midwife checking things out with her using questions, observation, and attention to her birth plan. Faith describes an ability to be quietly, physically present in the room but also available and attentive towards her when appropriate, when she would leave what she was doing and ‘take that time’ to ‘talk to me and look at me.’

In addition, Mary, Maree, Jovey, Helen, May, Katrin, Faith and Jennifer all talked about non-verbal communication from midwives. Mary described compassion through touch:

‘....I think there is something about the tenderness of a touch or the lingering of an eye contact or a squeeze of a hand er those er the tone
of someone’s voice that just indicates that they really do get it and I
think, em yeah I think that really valuable.....’

Mary 04 413-416

Mary went on to explain her midwife’s use of touch in labour:

‘……there was just like – almost like you would a baby actually, almost
like a grounding, so just putting a hand on, settling you, a hand over my
hand, a squeeze of a hand, erm [pause]………… there was just
something very settling about it and it was as simple as a hand on a
hand, er, or moving my hair out of my face because they could see it
was in my face, that nurturing sort of eh, wasn’t intrusive and er for me it
was really lovely…’

Mary 04 72-84

It is of note that Mary likened touch from a midwife to settling a baby. Mary (who is a
psychologist by profession) may have understood, on a theoretical and experiential
level, that caring touch is fundamental to all humans from and starts with the way that a
mother settles a baby. When she describes aspects of ‘nurturing’ touch from a midwife
which are ‘grounding’ and ‘settling’ she is indicating that this form of compassion
through touch helped her to feel more emotionally stable.

Jennifer talks about the intimacy of her birth experience and the importance of the
midwife holding her hand:

‘……she held my hand quite a lot {laughs} ……it is intimate isn’t it?
Because obviously you’re going through such a huge thing, to have that
just someone to hold onto and for them to do that for you as well and
feel comfortable with that, it is important’.

Jennifer 17 735-739

However, Jennifer was clear that for her, compassion from midwives was not primarily
about the midwife doing or saying things but much more to do with her calmly listening.
Her advice for midwives was:

‘….all I can say as from a mother’s point of view is just be calm,
collected and just listen, yeah’.

Jennifer 12 932-933

She went on to elaborate on the importance of listening and also on how she can
instantly recognise a compassionate midwife:
Jennifer 17 58-67

Jennifer could instantly recognise a midwife who is focussed on her and listening to her. This sort of focused listening that Jennifer sees as ‘the main thing’ was mentioned by ten women in this study. For Jennifer a midwife who listens and approaches her in a way that feels ‘comfortable,’ creates an instinctive trust from the outset. It seemed to be something that she recognised instantly by noticing if she was listening and also by reading the midwife’s attitude, facial expression, language and tone of voice. Maree’s words also support the instantaneous nature of recognising compassion in a midwife:

‘I instantly got that feeling from, you know like just the attitude, her face....’

Maree 05 310-312

Here Maree’s words suggest that the midwife’s attitude and facial expression can betray her aptitude for compassion. In contrast May had more difficulty explaining how she recognised compassion in midwives:

‘......I've seen so many midwives and they're all doing an amazing job but some of them....... just don't seem to have that, I don't know what it is! I can't put my finger on....... an interest in people almost isn't it?’

May 11.1 147-156

May noted that some midwives just have ‘that’ and some don’t. Yet initially she could not put ‘that’ into words and it seemed it might be an attribute with a mysterious quality which defies explanation. As she spoke about it she identified where it came from: ‘an interest in people’. Whilst many midwives were ‘doing an amazing job’, for May some did not have (or at least did not communicate) that immediate interest in the individual.

6.4.3 Available and ‘Tuned-in’ To Me

Twelve women experienced compassion from midwives when they perceived midwives were both physically and emotionally there for them. The simplicity of being physically present was striking. It may seem elementary that the midwife has to be physically there with the woman in order to demonstrate compassion. Yet women’s stories conveyed the importance of presence to them. Louise’s account of her experience in
labour supported this. Louise had a long history of anxiety and was anxious about the birth. She was unsure of what to expect in terms of midwifery care and was very pleased that a midwife was with her. She explained the way that the midwife behaved while she was with her:

‘[Midwife’s name] was with me most of the night which was when the labour sort of was happening and she was brilliant and I was really surprised actually that I had a designated midwife that stayed with me she literally didn’t leave throughout the whole thing and I didn’t expect that, I thought someone would just keep popping in and popping out um but she was with us in the room so if we dozed off she would just sit there or if we were talking, she would chat…..’

Louise 01 87-92

Louise’s extract indicates that she was surprised and at the same time pleased to have her own (designated) midwife to provide continuous, one-to-one care in labour. This was something that she had not expected. What she had expected was a more superficial, intermittent ‘popping in’ and was relieved and reassured by the one-to-one attention she received from a midwife who was available for her and stayed with her. There was an awareness of not just being physically present and available to her but very sensitive to her behaviour and preferences through the night, observing Louise and her partner and the mood in the birth room. She described the midwife practising watchful waiting in the birth room and (‘just sit there’) when they were resting but chat with them when they were talkative.

For Louise there was a sense of the midwife not just being physically present but respecting, fitting-in with and even mirroring their behaviour. This sensitivity and awareness of the woman while being with her was highlighted by women in different ways. Maree talked about the importance of the midwife having intuition and being able to ‘read’ the person and their situation. This ‘reading’ is something that goes on between the woman and the midwife and works both ways. In the previous section, Jennifer explained how she could instinctively recognise a compassionate midwife. In Mary’s account of her midwife being with her in labour, it appears that her midwife was able to make judgements about her and her needs:

‘…..and kind of also just quietly respecting the quiet when I wanted but physically being there. There was a really nice balance between eh I
got a sense that she was there and available to me, which was really nice, erm but equally she wasn't intrusive....

Mary 04 29-36

Mary's words present a picture of her midwife making judgements about the level of interaction that was appropriate and required. Through this attunement to Mary's needs she appeared to achieve a sense of unobtrusive, respectful presence in the birth environment.

The way that the midwife was with women took many forms when examined across and between all women in the study. The ability of midwives to read women and react compassionately was typically something that happened very quickly, in situations when they had never met the woman before and did not know what her situation was. Mary had such an experience when attending a postnatal clinic:

'...one midwife who I saw on day five when I literally burst into tears as soon as I walked into the waiting room, I had a terrible day on day five, real baby blue er my milk had come in that day and I was just a hormonal mess really em, and she literally scooped me up it was just lovely she scooped me up and walked me to a side room and sat me down and just let me cry. My husband had just gone to get a drink from the café and came in and she just did exactly the right thing she let me go for it and I remember crying for about forty minutes with her and again she gave me a hug, she put her arm around me erm, you know er really simple things like she went and got you know tissues and handed me tissues, just gave me that permission to have a good cry....'

Mary 04 126-136

Above, Mary remembers her experience of compassion on her ‘terrible day’ which she attributed to her milk coming in and the hormonal changes related to that. The fifth postnatal day is notorious for being a time when women feel emotional and upset. It is likely to be related to hormonal fluctuations, although the exact mechanism is not fully understood. It is widely experienced but unlike postnatal depression it is transient. It is sometimes referred to as the baby blues. Mary is describing her experience of her emotional distress as she experienced what (in retrospect) was baby blues. She was a ‘terrible mess’ and the midwife found her in this mess and ‘scooped her up’. She emphasised the phrase: ‘Scooped me up’. The word ‘scooped’ gave a sense of her emotional ‘mess’ being safely gathered together or held. She then took her to a private room, giving her time, space and permission to cry. Again, Mary remarks that it was a ‘really simple thing’ and yet within this act of compassion is the midwife’s ability to read...
the situation very quickly and react in a compassionate way. In Mary’s case this was simply to be with her in a space where she felt safe to ‘just go for it’ and express her upset. The ‘scooping up’ in this case equated to Mary feeling emotionally held or contained. The concept of containment is well-known in psychology and psychotherapy and has its roots in Winnicott’s (1965) work on how a mother attends to her baby’s good and bad feelings and provides a safe ‘holding environment’. Psychological containment in this respect encompasses ‘being-with’, empathy and full attunement to a person’s feelings while remaining functional and grounded and in this way, creating a safe environment for the person to express their feelings (Finlay 2014). Mary’s account of her experience with this midwife appear to demonstrate the features of emotional containment.

Katrin’s experience also involves a midwife very quickly tuning-in to her situation and sensitively acting on this. In this part of the interview Katrin, a first-time mother, explained there had been concerns over her baby’s weight loss which had led to a re-admission to hospital. Once the baby was gaining weight they had been discharged home for follow-up by the community midwives. However, Katrin was still having problems with breastfeeding. The midwife who saw her at home was a community midwife unknown to Katrin previously:

’I was a psychological wreck at the time………… my mum was here and my husband was here, he had paternity leave and mother-in-law was here, a bit of an unexpected visit from her side, all the way from India. As soon as she [community midwife] arrived you know, people started making questions, she sensed that there was a bit of tension in the room and erm she had a look at my stitches upstairs and she said ‘would you like to stay upstairs to converse how things are going? Downstairs is a bit crowded. Unless you would like us to stay downstairs?’ I said ‘No! Yeah, yeah, thank you! Thank you for er, without me having to go into detail she actually understood, she could feel some tension in the room. So we discuss about [baby’s name] and about breastfeeding programme and how difficult it was for me at the time and er she was very understanding, very understanding. She had er, you know she was listening more, she was listening first to what I had to say and she was kind of being observant to the situation ………it was like paradise, it was like finally someone that I can you know talk to and they can just listen without feeling, I don’t know, that they have all the answers…..’

Katrin 12 142-164

Katrin experiences compassion through the midwife’s ability to tune-in. The midwife came into the house and met Katrin for the first time but she immediately sensed a problem. Katrin’s words seem to suggest that the midwife’s ‘antennae’ were up; a
metaphor suggested by Andrews (2017) to describe a midwife’s ability to sense what is happening. Katrin’s midwife immediately sensed the situation and picked up on Katrin’s distress. She skilfully engineered a private and calm space in the house in which to communicate with Katrin on her own. The focus of this communication was just listening and the effect of that listening on Katrin was huge: Katrin went from being a ‘psychological wreck’ to feeling like she was in ‘paradise’. This demonstrates the superordinate theme: Being With Me, and reflects it’s emergent themes: Calm and Relaxed (particularly through creation of a calm environment), Available and Tuned into Me (atuned to what was going on for Katrin) and Communication (specifically through listening). Katrin’s words above therefore reflect the interrelatedness of all three theme elements within this superordinate theme: Being with Me.

6.5 Theme Three: Relationship

This theme explores women’s experience of compassion through a relationship with a midwife. Aspects of this superordinate theme were evident in all women’s narratives (17/17). Relationships usually build over time, and that appeared to be the case with some of the women who had experienced continuity from a midwife during the course of their pregnancy or even over more than one pregnancy. However, for some women it could also develop quickly during one episode of care. Relationship moves beyond a midwife’s attentive interest to a feeling that the midwife was interested in them as an individual person and genuinely cared about them. It incorporates four emergent themes and Relationship was chosen as the overall name for the theme because all of the emergent themes in this group related to the nature of the woman/midwife relationship. These were:

- Developed a Relationship with Me
- Understood Me and Could Personalise My Care
- Actually Cared
- Like Friend or Family

6.5.1 Developed a Relationship with Me

A relationship can be defined as the way in which two (or more) people (or groups) are connected, feel and behave towards each other (Collins Online Dictionary 2015). Most women in the study (12/17) referred to how they had a relationship with the midwife and that it was within this relationship that they experienced compassionate care. This
was not necessarily the midwife that they had seen most often, although, for some, seeing the midwife more frequently helped to develop the relationship as in Imogen’s case:

‘….she was really supportive and it was fortunate that I saw her the same time on a few occasions, I think that was, she specifically said that she was going to try and come back. I think that continuity really helps I think in developing your confidence because you’ve already built up that relationship with that midwife........ she wasn’t in a rush to go away, she had time to listen to me, care for what I was saying and seemed to be genuinely concerned and things like remembering them the next time, rather than having to look in my notes and say ‘oh you’ve had this this and this’, she knew and she’s like ‘Oh there was this last time, have you, how’s that gone?’ and that kind of level of detail. I know that’s only small and she probably just read over the notes before she came in, cos I don’t think I would be able to remember everybody that I’d seen but even if that’s what it was, it made me feel valued.’

Imogen 10 279-209

Imogen was talking about compassionate care from her community midwife who was not the same midwife she had seen during her pregnancy. She appreciated the continuity from this midwife at her postnatal home visits which she felt allowed a relationship with this community midwife to build and she links this to developing her confidence. Both Imogen and the midwife appeared to value the continuity which would allow a relationship to develop: ‘she specifically said that she was going to try and come back’. Imogen reported this as evidence that the midwife seemed ‘genuinely concerned’ for her, the implication being that this was something more than being professionally concerned. This concept is explored further in Section 6.5.3. She valued the fact that the midwife also remembered details about her situation and followed up on these. Imogen saw this as evidence of her midwife’s genuine concern but she was also realistic. Perhaps the midwife ‘just read over the notes before she came in’? She realises that a midwife may not be able to remember everybody’s details. Moreover, she is showing that she has thought about the midwife and the limitations on her due to her workload. She has some insight into and even empathy for the midwife’s situation. Imogen can see the practical challenges involved for a midwife in trying to remember each woman and her situation, when trying to provide woman-centred, compassionate care. However, Imogen did not seem to mind if it was a matter of checking the notes beforehand rather than remembering the details, it still made her feel valued. From Imogen’s perspective the midwife was not only taking the time to listen to her, she had also taken the time to re-familiarise herself with her history and what was going on for
her. Imogen’s experience was that this midwife valued her as an individual. It would seem to be reciprocal; the midwife valued Imogen and Imogen valued the midwife and this characterised their relationship. Reciprocity within the relationship women had with their midwives was evident in other women’s accounts:

‘The community midwife this time, she was the same one that I had with [first baby’s name] but I didn’t feel like I gelled as much with her the first time. But this time round I found that when I opened up more to her, she was really supportive and she saw me a lot more than she needed to because she knew I was really anxious about pain relief and things like that so she, she was really good this time, I mean in that she did book extra appointments and she gave me a number, obviously you have a number anyway but she made it clear that she would talk to me or help if I needed her.

Faith 15 238-246

For relationships to ‘gel’ they require the input of both parties. Faith described how her relationship with her community midwife developed once she ‘opened up more to her’. By revealing more of her own vulnerability and her need for compassion (her anxiety) her midwife responded by stepping up to meet her needs. Given that compassion is defined as a response to suffering (as explored in Chapter 3) Faith’s account appears to provide an illustration of this, in the way her midwife responded to Faith ‘opening up’ about her anxieties.

In contrast, Beryl’s experience of what she saw as uncompassionate care, was with a midwife with whom she could not develop a relationship despite continuity. She had the same community midwife throughout her pregnancy and the postnatal period but during her interview she seemed upset by the absence of relationship.

‘I just felt from day one really, she was going through the motions…..it was a bit cold’

Beryl 08 154-176

‘…”I just need to answer these and I’m not going to ask anything else cos all I need to do is answer these”. It just felt like that really, it wasn’t a conversation…..it makes you feel that you’re not really part of a conversation because it’s ‘How’s your bleeding?’ ‘How’s your wound?’ [she impersonates the community midwife: bland expression, hurried disinterested voice] That’s how it was, really [sounds upset].’

Beryl 08 205-216
Beryl seemed not just disappointed but distressed that continuity with her midwife did not lead to warmth and connection. In Beryl’s account the midwife expressed her own agenda: “I just need to answer these.....” Beryl felt that she was not part of any conversation in which her own agenda could be addressed. Contrary to Beryl's experience, accounts from many women illustrated that a meaningful relationship with the midwife did develop over time. Jessica's relationship with her community midwife is one such example:

'I'll start with our community midwife er she has been absolutely fantastic. I've known her now for er, [name of midwife] its four and a half, so five years, and we've had the same community midwife throughout, three different pregnancies and one termination so er it has been a bit of a traumatic experience erm and she has been an absolute rock actually, she's been brilliant erm with [Name of daughter 1] she, she was there and she was great but it was only when we lost [Name of daughter 2 who was stillborn] really that I would say she really stepped up to the plate and she came round here, she gave us hugs, she was drinking tea and coffee with us and erm she was just she was here in a way that erm I think, in a way that other people couldn't be because she, whether she’s seen it before or she knew something about it, she, she just seemed to know how to treat us and she was happy to talk about [Name of daughter 2 who was stillborn] very openly erm but she was also happy to not dwell on the grief and despair we might be feeling but to sort of perk us along. And then subsequently with [Name of new baby son] she handled me brilliantly because she was very reassuring when I was getting a bit upset about movements or non-movements erm and she she treated me in a very, I guess in a sensitive way that reflected the circumstances we'd been through as a family, she understood where we were coming from ......she just dealt with me very sensitively which was lovely, erm so she’s been fantastic.....it almost feels like she’s become a family friend rather than my midwife which is lovely'.

Jessica 07 21-45

Jessica had the same community midwife for five years and through four pregnancies. However, it was following the loss of her daughter through stillbirth that her midwife ‘really stepped up to the plate’. In response to this terrible loss Jessica perceived that her midwife responded with compassion. She describes non-clinical activities of hugging and drinking tea and coffee, very basic and familiar forms of comfort and connection. As in the previous theme, there is a sense of the midwife knowing how to ‘be with’ Jessica, but in this example it is demonstrated within the context of an established relationship and informed by her knowledge of Jessica and her family. Jessica is reassured by this relationship because this midwife knows something about who she is and understands her anxieties in her current pregnancy. Her midwife has
used this knowledge to personalise her care and shows sensitivity to her situation and has responded to her anxieties by giving Jessica access to her when she needs it. Compassion through the personalisation of care is highlighted in other women’s narratives in Section 6.5.2. Jessica felt that the relationship she had with her midwife had become like that of a ‘family friend’, a theme that will be explored further in Section 6.5.4.

6.5.2 Understood Me and Could Personalise My Care

Other women’s accounts of compassionate care demonstrated how a relationship enabled the midwife to see the woman as an individual and understand her situation, hopes, and fears. Matilda recognised this as a feature of compassionate midwifery and her account is a clear example of this:

‘Um I think it was the level of understanding that people saw in the situations that we were going through…. I was on Birth Unit they were very aware that I wanted to have a water birth and we really, really wanted to be there rather than on the labour ward….. my waters broke……and there was meconium in my waters and the midwife went “Oh” and you could see that she was upset that there was meconium in my waters because she knew that that meant that I wasn’t going to get the type of birth that I really wanted to have and I kind of working through that realisation of her and she’s like “I really know that this is what you want and we want to try and support you in that” but I could see how disappointed she was [emphasised] by it and it wasn’t just her telling me…..you could see it in her face that she was really disappointed that we weren’t going to get what we wanted to happen……it was that empathy that the midwife had with us that was so nice and made us feel supported and that it wasn’t just them saying that things needed to happen, they wanted to support us as much as they could to do what we wanted to do.

Matilda 03:13-32

It was the ‘level of understanding’ from the midwife that Matilda seemed to find so important. The midwife knew what Matilda’s birth preferences were, but more than that, it appeared that she wanted that (for Matilda) too. The ability to empathise or put herself in Matilda’s shoes is illustrated here. This sympathetic connection between Matilda and the midwife was seen as compassionate support and highly valued by Matilda. The importance of this empathic understanding was echoed in other women’s narratives. It seemed to enable compassionate midwives to understand not just what but also who was important in the woman’s life and include them in their care. Matilda described how her community midwife demonstrated this during some of her antenatal appointments:
Matilda described how the midwife showed compassion by attending to her young daughter. Matilda was put at ease by her daughter being put at ease, because their needs and emotions were closely linked. Matilda recognises that this is not something midwives ‘find in a protocol’, a phrase that suggests that she recognised it as something over-and-above standard or routine care; it was personalised, family-centred care. Matilda was not simply seen as a pregnant woman attending for her antenatal examination but she was seen in the context of her role within her family and the importance of those in her family to her life was understood. There was a sense that Matilda’s midwife was not just thinking about the pregnancy, but about the evolving family unit. This quality of extending compassion to those people close to the woman, was echoed by Helen:

‘…..this may seem a bit of a silly thing but because of this all happened at night and my husband stayed with me, she got him a blanket and pillows and then she made us some toast and a cup of tea as well cos we were both really tired cos we had been at it for days, so just the little things like that really made a massive difference. And it was nice that she was really supportive to him as well……he was really tired as well and I wanted to make sure that he was OK and yeah cos obviously [laughs] you’re kind of worrying about your husband as well, you want to make sure that everything’s alright for them cos they’re just stood watching you go through this and they can’t really do anything about it and we’d been in this situation for a few days by this point and nothing had really progressed so it had been quite long and drawn out and I was quite tired and I knew that he would be quite tired so it was nice that she was really supportive to him as well.

Helen 09 73-80

Women seemed to appreciate a midwife looking after their partners, and particularly when they were in labour. As with Helen, some women talked about being concerned and even worried about their partner’s situation, yet not being in a position to address this themselves. By providing tea, toast and other home comforts to her husband,
Helen thought that the midwife was showing compassion. It made a ‘massive difference’ to Helen because, despite being in labour herself, she was worried about him. To Helen it seemed that the midwife was able to acknowledge Helen and her role within her relationship and meet her needs by caring for her husband on her behalf. Both Matilda’s and Helen’s accounts illustrate a common experience of compassion from midwives within the interview data, that of midwives who specifically attended to those things (and people) that the woman cared about.

6.5.3 The Midwife Actually Cared

This sense of relationship and of the midwife really getting to know the woman and what matters to her, seemed to link to women sensing that their compassionate midwife cared about them. Eight women’s experience of compassion included an awareness of the midwife really, genuinely, or actually caring about them.

‘…I felt like they er genuinely cared about me and were happy to look after me and get me better so yeah, er I instantly got that feeling from, you know like just the attitude, her er face…..just genuinely concerned…’

*Maree 05 309-314*

‘…..they actually cared and you could just see that they actually cared. And the day we left the high dependency and we went into the ward erm, [name of midwife] actually came, she’d finished her shift but she came to say goodbye, purposely she came to say goodbye, she should’ve gone home like half an hour ago but she came to check we’re OK and say goodbye and see him and see us and that was just like – you really didn’t have to do that, it was almost like we obviously, you feel so close to them in that time because you’re in that small room, you feel like they really did care about us……..You could tell. You really could…’

*May (2nd) 145-154*

‘I guess what stood out with those two was that they just really cared about you whereas some of the midwives and, maybe it was a consultant or a doctor, were just more service orientated and just more like checking on you based on the time rather than your individual needs’.

*Lisa 02 38-41*

Maree, May and Lisa all felt that they could just tell that the midwife cared. Maree felt it was in her attitude and saw it in her face, suggesting that there is something in a midwife’s non-verbal communication that is important in that is reflects their authenticity (this has been seen previously in section 6.4.2). On the other hand, May felt that the
midwife taking the trouble to come and say goodbye after her shift was finished, was proof of a special kind of closeness and genuine caring. Whereas Lisa linked real caring to care that is more than ‘just providing a service’, and she makes a distinction between midwives who carry out time-limited ‘checking’ and those who really cared about her as an individual.

‘Actual’ caring was closely connected to the relationship and the understanding that developed within that relationship. Jovey, whose first baby was stillborn and second pregnancy ended in a miscarriage, was 34 weeks pregnant at the time of the interview. She talked about how her midwife knew her and therefore understood her. This gave Jovey a strong sense of her really caring for her and caring about what happened to her as she explained in her words below:

‘….she just struck me that she really cared and that she really, obviously she hadn’t lost a child herself, but that, that she really erm understood or I suppose could empathise is probably the right word erm with with what happened…. I have always felt like, like she kind of specifically cares about…… about my future prospect of having children and sort of helping me get the information I needed for that kind of goal and like now I think its I feel like she actually cares about me having this baby alive and well and about me having, I suppose as far as is possible a less stressful experience

Jovey 06 47-57

A feature of this theme of relationship is that it is not just for a moment in time; it is concerned with the past and the future. This is evident in Jovey’s narrative above. Jovey knew her midwife from her past pregnancies; this midwife knew about her past. For Jovey this seemed to be key to the midwife understanding and empathising with her situation as well as caring about her future. This concept of genuinely caring over a period of time was seen in Mary’s experience when she was reunited with her midwife (who was with her in labour) when she returned to labour ward to collect something she had left:

‘…… I went up to the ward to pick it up about two weeks after she was born and the midwife was on shift and what was lovely was that as I walked onto the ward she recognised me and came rushing over and she said, ’Oh I’m so glad to have seen you’, cos we talked a lot about running, ‘I’ve been thinking about you cos I bought a new pair of trainers this week’ and you know and she said and that was really nice. She said ‘I was really disappointed for you’ and it was nice cos she realised how hard I had worked to get a natural birth and how important it was to me and she said something like ‘I was really sad and disappointed for you
that it didn't work out how you wanted’ erm it was nice to know and get a
sense that I had very genuinely been in her thoughts after that, after she
had left the room and I think that really shows compassion from
someone, you know, you’re not just in their mind at the time, they take a
bit of you with them. She was absolutely lovely, she also gave a nice bit
of self-disclosure, not inappropriately you know but er I knew that she
had a couple of kids, I knew what their names were and that was really
nice as well cos you got a sense that she had been through it and she
kind of knew where you were, it was nice........I think I said it was a bit
shit really wasn’t it after fifty-six hours and all that hard work and she
said ‘yeah it was a bit shit’ and that, that, that to me was such
compassion, she was really where I was at with it, I felt really listened to
and contained.....’

Mary 04 227-244

Here there is a sense of the nature of the relationship that she had with the midwife.
When they were reunited, they picked up where they left off and the midwife referred
back to their common interest in running which they had obviously discussed when
Mary was in early labour. In the midwife’s open expression of sympathy there appears
to be a genuine sense of her understanding and sharing in Mary’s disappointment.
Mary’s words provide a sense of relationship which has extended beyond her care in
labour. She feels that the midwife has taken a bit of her with her and vice versa. The
midwife offered something of her background in a ‘nice bit of self-disclosure’ so they
knew something of each other’s personal lives and this reciprocity and shared
understanding appeared to strengthen the relationship. This is expressed particularly
well in the mirroring of language in which the midwife concurs with Mary that her
experience of labour was indeed ‘a bit shit’. This simply and effectively acknowledges
and validates Mary’s feelings about her experience and demonstrates caring through
acknowledgment and acceptance of her phrase. It appears that it was this expression
of the midwife’s solidarity with Mary, as a person (rather than a purely professional
response) that Mary sees as compassion.

6.5.4 Like Friend or Family
Jessica, Mary, May, Jess, Katrin, Jane and Jennifer all talked about how the
relationships they had with their compassionate midwives were, at times, less like
relationships with healthcare professionals and more like that of friends or family
members. Although there was convergence around this theme, there was divergence
regarding the specific type of relationship. Women talked about the midwife being like a
friend, mother or sister and sometimes a mixture of these. Jane talked about her
midwife being motherly but she also experienced a sense of 'sisterhood'.

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‘…..that woman-to-woman exp, er, sisterhood is what I would say, that feeling of sisterhood in that it’s OK we all go through it and you’re doing you’re doing your best…………perhaps if your own mother went into the birth with you or your own sister, you might not, you know….. I didn’t have that and Caesarean mums don’t have that……’

Jane 14 284-286

Jane appears to be talking about a feeling of closeness to another female and wonders if it would be needed if ‘your own mother’ or ‘own sister’ was in attendance. She refers to this not being allowed for women having a Caesarean section like her.

May was interviewed both before and after she had her baby and at different times in both interviews she talked about her experience of compassion from a midwife who was something like a mother or friend.

‘…it was almost quite Mumsy, but not, like quite, familiar, like, it’s a sort of thing that a friend would do……’

May 11.1 64-66

‘…its just like the er Mumsy is not the right word but it’s that sort of….. I can’t put my finger on it, but its just that caring and its just like unconditional worth….’

May 11.1 139-147

‘….. I really can’t describe how wonderful she was ……it was like having a friend there that I’d never met before.’

May 11.2 277-279

As May talked about her compassionate midwives there was a sense of her struggling to find the right words. Her use of the word ‘mumsy’ suggests a mothering element but she appears uncomfortable with the word. This may be due to the adjective ‘mumsy’ having an association with the dowdy, dull or unfashionable (Oxford Living Dictionaries 2018). She settles on the midwife being like a friend that she has never met before. The sense of a compassionate midwife being like a friend was echoed by several women including Mary:

‘…..both of the midwives that I saw in labour were definitely compassionate, er the first midwife I saw….. was absolutely brilliant um and I think she offered compassion in a variety of ways, she was very personable, she was very human, we talked about normal things em she helped me feel very comfortable, it felt like being there with a friend
When Mary remarks on how her midwife was ‘very personable’ and ‘very human’, she seemed to be suggesting that the midwife was relating to her as a fellow human-being rather than simply her health care professional. Yet there is no suggestion that this is unprofessional behaviour but rather that midwifery care was enhanced (more compassionate) through a feeling of being there with a friendly person or friend. This is at odds with the more traditional view of the professional who is obliged to present a professional ‘face’ or attitude as a means of maintaining clear professional identity and boundaries. Mary talks about the midwife taking an interest in her as a person rather than just as a labouring mother. These words seem to say something about the underlying attitude or model of care. Within a medicalised model of birth a pregnant woman has historically been seen as a means to an end and not an end in herself. Being seen as ‘more than a labouring woman’ suggests a social model of care in which birth is much more than the physical parturition of a baby from her body to the outside world. It is a model which values the woman as an individual and sees childbirth in terms of its meaningful, social significance within a woman’s life. This is explored further in Section 6.7.3 of this chapter.

Sometimes when women described the characteristics of a compassionate midwife from their experience they talked about the age and experience of the midwife as being relevant. There was no consistency across all women participants regarding this. Some women found younger midwives more compassionate while others thought that older and more experienced midwives had the edge. Once again this included describing their midwife as like a friend or a mother.

‘...the actual midwife that delivered..... she was an older midwife, she’d be sort of my mum’s age, fifty-five, fifty-six? So she had compassion in a different way, you know, like in a motherly way which I found that was really nice....’

Jess 13 165-168

Jane was very complimentary about older midwives whom she certainly appeared to favour:
Jane: ‘...the older midwives......I do feel more reassured by the older ones I’ve had before, but that’s just my personal.....’

Interviewer: ‘Do you think the older midwives are more compassionate?’

Jane: ‘Yes. That’s how I felt. I don’t know why! I felt they were more maternal with me, more nurturing with me....cos I was very, very vulnerable, that’s how I felt, very vulnerable and exposed and almost regressed to being child-like myself in that fear. I needed someone to, yeah mother me, you know, my husband was with me but it’s not the same. So I needed that mother figure to reassure me that everything was going to be ok and I trusted her, that it would.’

Jane had tocophobia and felt very frightened about labour and birth. She felt safer and more reassured with the more experienced and older midwives and yet she was almost embarrassed in her declaration of this. Nevertheless, to her they were more compassionate because they were more maternal with her. She sees this maternal behaviour as a much-needed response to her feeling vulnerable and child-like in her fear. This concept of mothering-the-mother was described in a number of ways by women and could be linked to many other caring behaviours like touching, hugging, holding, settling as well as providing comfort and sustenance. Making tea and hot drinks sometimes played a part, and tea as a symbol for compassion will be explored in section 6.7.1 of this chapter.

Although Jane’s experience was with an older midwife, nurturing or mothering behaviour from midwives was described in midwives of different ages, personalities and genders. This suggests mothering was a skill which was demonstrated as an appropriate response to their needs for some women rather than a mother-like characteristic of the midwife.

6.6 Theme Four: Empowerment

This superordinate theme addresses the way women in this study experienced compassion through interactions with midwives that made them feel more empowered. Empowerment in a midwifery-specific context emphasises the woman (and her partner) developing their awareness, abilities and decision-making through a personal growth process and has been identified and discussed in the concept analysis in Chapter 3 of this thesis. There were three emergent themes. These are:

- Giving Information
• Teaching and Coaching
• On My Level

All women’s accounts touched on a sense of empowerment by discussing at least one of the above. Giving Information emerged as something that women saw as compassionate care because it helped them to understand more about what was happening and/or what to do. Teaching and Coaching, although closely linked, emerged as another distinct and compassionate act. Teaching and coaching by midwives appeared to build on the information given, through showing, demonstrating, supporting and supervising techniques as well as through encouragement and positivity. The emergent theme: On my Level refers to the manner in which this informing and teaching and coaching was carried out. Together these sub-themes characterise the ways in which all women experienced compassion from midwives which acted to empower them.

6.6.1 Giving Information

Most women (14/17) emphasised the importance of being given information about their care and what was happening to them and/or their babies. There was convergence across most cases that information from midwives was seen as a part of compassionate care to them, as is evident in this part of Jess’s interview:

‘I think the big thing was putting you in the know. They all explained things beautifully which in itself is compassion cos I, I’m then, what’s the word? I’m in the knowledge, I’m in the know…..if you don’t have the knowledge, you don’t know what you’re dealing with, you don’t understand the situation and then that’s when things spiral out of control. Whereas they, I think it is a form of compassion cos you are giving that knowledge and you can’t give anybody any more than that I think sometimes’.

Jess 13 118-129

Jess thought explaining things and putting her ‘in the know’ was a demonstration of compassion and the way this seemed to work for her was by increasing her understanding, which in turn, provided her with a feeling of inclusivity and involvement and control. This seems central to Jess’s experience and being outside of this (not being in the know) would exclude her from an understanding of her situation. This could cause the situation to ‘spiral out of control’, a phrase which suggests a frightening chaotic feeling. It appears that midwives who were able to increase Jess’s knowledge,
increased her sense of agency and she introduces the idea of knowledge as a gift that the midwife can give the woman.

Women identified midwives who took the time and made the effort to explain aspects of care to them. For example, May was 34 weeks gestation and an inpatient on the antenatal ward (because of pre-eclampsia) in the example from her interview below:

‘Yesterday she put me on the monitor and I was just kind of looking at it and she went through every single detail with me and it’s a, I’ve been put on the monitor numerous times but nobody’s actually gone through every single little bit with me and I was like ‘that’s really useful actually’. She’s just got that you know ‘this is what’s happening, this is what we’re doing’

May 11.1 278-283

As an antenatal in-patient with a serious pregnancy complication, May had been ‘put on the monitor’ for electronic fetal heart monitoring many times. She described herself ‘just looking at it’. Her words conjure up a picture of her being the subject of an assessment using technology she did not understand. The machine she would have been connected to would have plenty for her to look at and wonder about. Fetal heart monitoring equipment has controls, numeric displays and also produces a graph. It may also have been making noises, usually the amplified heartbeat of the baby and even the bleep of an alarm, a common event when on ‘the monitor’. It seems evident in Jess’s account that the midwife who went through ‘every single little bit’ with her was addressing Jess’s need to try to understand what was happening and why. Jess uses the phrase: ‘She’s just got that, you know “this is what’s happening……”’. Here May seems to be making reference to an ability or special quality that this midwife had. Recognising the need for information and then explaining everything comprehensively in a way May understood would have required knowledge, motivation and good communication skills. It could be that these are the qualities May recognised that the midwife had ‘just got’. In any event this detailed sharing of information made a difference to May and was one of her experiences of compassionate midwives.

In contrast, Esme also experienced compassion from a midwife who had the ability and knowledge to be able to provide information and in addition the possible options available to her. Esme talked about her preparations for the birth of her second child. Her first child had been born by emergency Caesarean section and she was unsure
about her plans for her forthcoming birth. Below she compares her community midwife and the midwife who had shown her compassion in this way:

‘I felt that everyone who I saw treated me nicely…… I didn’t feel they were, maybe not fully compassionate but kind of nice interactions and stuff …. I think one of the other differences with those compassionate experiences and with say my community midwife was that I think I trusted [name of compassionate midwife]….. I think because she seemed more knowledgeable and she was giving me options it felt like I trusted her cos she knew what she was doing whereas although I really liked my community midwife on a personal level, I don’t know if I kind of trusted her to get things done………she [compassionate midwife] just kind of felt a bit more on the ball and a bit less fluffy’.

Esme 16 333-343

Esme made the distinction between ‘niceness’ and compassion. To Esme there was more to compassion than being nice and ‘fluffiness’ (presumably a version of niceness that the community midwife displayed) was different to compassion. The analogy of ‘fluffiness’ suggests somebody who evokes feelings of warmth and comfort but without the necessary substance. It seemed that her community midwife was nice but she did not trust in her knowledge and abilities. For Esme, this midwife seemed less capable of providing relevant information and explaining all her options. In comparison the compassionate midwife she talks of seemed ‘a bit more on the ball’, suggesting a superior level of knowledge and competence. It appeared that the midwife in this example had a grasp of the issues and could present Esme with information that she needed to make decisions about her birth. In Esme’s experience of these two midwives there was the implication that the compassionate midwife had more potential to help Esme to make her own decisions and move forward, in a way that the ‘nice’ community midwife could not.

In the same way, many women talked about being provided with information as part of compassionate care. Sometimes this was part of supporting women’s choices as in Matilda’s words below:

‘…they give you all the information that you need and then they respect your decision that you make from that and not just kind of “Oh OK then” [said without feeling or enthusiasm] but “OK then we will go with that!”[said with feeling and enthusiasm].

Matilda 03 102-105
Above Matilda explained about her experience of midwives providing her with informed choices and how they respected her decisions. In her experience they went beyond respect, they showed an enthusiasm and inclusivity. When she impersonated the midwife who says “Ok then we will go with that!” it suggested both positivity and inclusivity. This feeling of respect for women’s decisions and yet also inclusivity, which implied that they were in this together, was echoed by other women, for example Louise:

‘I felt that this was an experience that we were all in together and it was my decision and that, the various midwives supported me in my decision I didn’t feel at any point that this was just happening to me and that I was just passive in it…. even with the pain relief and with the pethidine and when you’re in that that state you’re not really able to make decisions because you know there’s too much going on, you’re too emotional, you can’t think straight, your pain, you’re sleep deprived and eh and I was like “oh I don’t know what to do! Do I do this? What do I do”? So she was able to help and guide me in making decisions but it was very much my decision, it wasn’t just this is what you should do kind of thing….’

Louise 01 343-358

This extract highlighted Louise’s experience of her midwife providing both information and choices. Further, Louise simultaneously felt that she was the one making decisions about her care and yet that they were ‘all in it together’. She points out that even with decisions about pain relief in labour when there were many reasons why she felt decision-making might be impaired, her midwife helped and guided her to actively make her own decisions. Louise’s experience suggest that at different times she needed different levels of support with her decision-making but even when she needed more help and guidance with it, it was not from a position of power or authority (‘it wasn’t just this is what you should do kind of thing….’) and as a result Louise appeared to retain a sense of autonomy.

Some women gave accounts of midwives who helped them access information from other sources and were advocates for them when they sought information or input from other health care professionals. Lisa was expecting twins and had given birth to her first twin vaginally but the second twin was not in the ideal position for vaginal birth and the decision was made to go to theatre for a Caesarean section.

‘In the theatre……I was all ready to go and I was like “wait is there any alternatives?” but they didn’t hear me and then one of the midwives did and she said “Wait! Mum wants to know if there are any other options?”'
Then the consultant explained to me……so er there is still some compassion there’.

Lisa 02 110-123

As Lisa remembered the drama of the event she also remembered the element of compassion. She had a question but it seemed ‘they didn’t hear’ until one person spoke up as her advocate and insisted they ‘Wait!’ By ensuring that she was heard, acknowledged and answered Lisa received an explanation and reflects, even in an urgent situation, ‘there was still some compassion there’.

6.6.2 Teaching and Coaching

Teaching and coaching from midwives was included in six women’s experiences of receiving compassionate care. It could be entirely practical in nature although it frequently involved psychological support to achieve or do something. It seemed to be especially beneficial at times when women were losing confidence in themselves or in their bodies. Esme’s first baby had been born by emergency Caesarean section. She described how she felt empowered by a conversation with a midwife regarding her forthcoming second birth:

“I felt quite empowered by that session to go for a vaginal birth whereas I’d been quite anxious about erm having a section because I didn’t want a C section…..because of my toddler I didn’t want to have the recovery process and all and all of that. But I wasn’t, I don’t think I completely trusted my body to be able to deliver a baby vaginally erm so in that session she was, she kind of listened to my experience and erm was basically kind of help build my trust within my own body again so she was saying, she listened to my experience and then was saying ‘well your body was doing all the right things…… there’s no reason why you can’t go for it again and actually you know, seventy per cent of women successfully deliver but I think you’ve got a better chance because you’re doing hypnobirthing practice’ and all these kind of things. So she really kind of empowered me….. it just gave me a lot of confidence to kind of go for it…”

Esme 16 22-40

Esme described the coaching activities the midwife used to build Esme’s trust in her ability to birth vaginally. The issue seemed to be a loss of confidence in herself and her body. When Esme doubted her body the midwife reminded her that ‘her body was doing all the right things’. In this way the midwife was helping Esme to shift her mindset from one of feeling disempowered because her body had previously failed her to feeling empowered because she understood that her body had not failed and was
capable. The midwife provided factual information about the likelihood of Esme having a vaginal birth and was positive and encouraging about Esme’s hypnobirthing course, which she felt increased her chances even further. This can be seen as a coaching process as it was focussed on increasing Esme’s knowledge and confidence and supporting her to move forward in a positive way, towards her own goal of planning a vaginal birth.

Jessica also talked about supportive coaching from a midwife who helped her to believe in herself:

‘She believed in me at a time when I didn’t believe in myself with [name of baby], giving birth to her…..the doctor was saying “we want to take you to theatre…….” and [name of midwife] believed that I could get her out by myself if they just give me a bit more time……and she said to me “you can do this” and I just looked at her and said “OK lets do it then” and we did it and [baby’s name] came out and it was the best, best thing that we could have done…..’

Jessica 07 526-533

Jessica felt that her midwife ‘believed in her’. As a result, Jessica was inspired to believe in herself. Jessica’s story suggests that the midwife was not only her enthusiastic coach but acted as her protagonist and champion. Jessica felt a huge sense of achievement and remembered it as something that they did together. She talked about the experience in a similar way to how an athlete might talk about winning a race. The athlete is the one performing but there is a sense of their coach or trainer being in it with them.

Compassionate care when learning how to breastfeed or when experiencing breastfeeding difficulties was apparent in several women’s interviews. Imogen’s experience of a midwife who helped her find a way of overcoming her breastfeeding problems is an example of this:

‘I can still see her face, still remember her name, she was really lovely….and I think really boosted my confidence with breastfeeding in particular and she made it really relaxed which I found is the key….I think the way that she treated me really set me up for that, I’m still successfully breastfeeding…..she helped me do that….. she taught me how to lie, er do the lay down breastfeeding, where you lay on your side. Cos I was really struggling on my right breast er to feed….and what I’ve done is fall back onto that technique when I’ve struggled to breastfeed cos I’ve almost remembered feeling relaxed at that time, I can feel her
talking me through it almost again and remembering back to that time…. it’s been really invaluable the technique that she taught me there’.

Imogen 10 246-248

This quote implies not just giving information but also higher level skills such as teaching and coaching, which increased Imogen's confidence and ability to breastfeed. She talks about how she can still ‘feel her talking me through it…’ Interestingly Imogen said ‘feel’ and not ‘hear’. There is a sense of the way that the midwife’s approach to teaching her how to feed her baby while lying down had become an embodied and enduring memory.

Jessica also talked about the midwife’s key role in building women’s confidence in their body:

‘…..its very easy on day two or three to think ‘this breastfeeding is incredibly difficult and I don’t know if my baby is getting enough and I’m so unsure of myself erm and I’m just going to go home and put a bottle in its mouth because I know then what its having and I know it’ll be fine’ erm and and its having the confidence to know that your body is up to the challenge and it will kick in and do what it needs to do and I think it’s the midwife in the first three days that gives you that confidence to, to enable you to succeed…’

Jessica 07 489-494

Women talked about how the arrival of their new baby revealed their lack of knowledge, skills or confidence in caring for their babies and how midwives engaged in demonstrating, teaching and coaching in very practical ways helped them to overcome these problems:

‘I think your confidence goes, you don’t know what you’re doing if its your first baby……I think its massive at that time when you are. I was clueless, I’d never been around a baby, I never knew how to change a nappy, I didn’t know anything so to me I was a rabbit in the headlights….the midwife in the hospital, she showed me how to wind the baby which was great, no one had showed me up to that last day erm she showed me, she let me have a go and she could watch me erm it just helps…’

Beryl 08 268-289

Beryl described her loss of confidence and ‘feeling like a rabbit in the headlights’, being shown how to help her baby was something that helped her with this. There is a sense that feeling ‘clueless' because she was unsure or unable to provide care for the new
baby was frightening or distressing. Practical teaching from a midwife was recognised as a compassionate response to this. Both of May’s experiences below exemplify this:

‘….it was just the way they helped [partner’s name] with him as well cos obviously I couldn’t get out of bed. Its really quite heart-breaking that you know, you can’t change your baby and you can’t put clothes on him for the first time but they er, they helped [partner’s name] with all of that which was lovely cos he had no idea [laughs], we hadn’t had any practise had we? [talking to her baby who is in her arms] We didn’t know what to do with you. But they were just wonderful like that. Like [name of midwife] one night spent about half an hour winding him with us….’

May 11.2 135-142

‘….she helped daddy bath you for the first time cos mummy couldn’t do it, didn’t she? [talking to baby]. She was lovely, really, really lovely. Yeah just really understanding cos it’s a bit scary erm when you’ve not done this before, you’re like suddenly you’ve got this baby and you’re sleep deprived, you don’t really know, you don’t know if you’re doing the right thing, worrying about everything.

May 11.2 340-346

In both the above excerpts from her interview, May remembers the practical help they had with aspects of baby care (changing, winding, bathing) which their midwife guided and assisted them with. What appears to come through is May’s realisation of how ill-prepared they felt to carry out these tasks and how fragile and vulnerable they felt at this time. This was not just physically (cannot get out of bed and sleep deprived) but emotionally (heartbroken) and psychologically (worrying about everything) and how demonstrating and helping with this care was so valuable to them at this time.

6.6.3 On My Level

Most of the women in this study indicated that it was not just what midwives said and did but the way that they said and did things that made their support compassionate. Women wanted information, teaching and coaching when it was appropriate to their needs, but they did not want this from a position of power; they wanted to be treated as equals. Nine women reflected on how the approach used by midwives was key to helping women feel respected, involved and empowered. Jess was attending the hospital with reduced fetal movements in late pregnancy:

‘I was obviously anxious cos he’d had reduced movement erm, so that was , yeah, I was anxious when I got there and she was just very relaxed, she was clearly very knowledgeable erm but not, but she didn’t talk over me, she sort of explained things in layman’s terms which is
good, you need that. You need everything explained and just, no question was too silly or trivial and yeah really put my mind at rest and, so she definitely showed compassion to our situation’

Jess 13 40-47

Jess seemed reassured that the midwife was knowledgeable but it was important to her that the midwife also respected and listened to her concerns and ‘didn’t talk over me’. The midwife’s approach and choice of language (layman’s terms) made Jess feel comfortable enough to be able to ask anything because no question would be ‘too silly or trivial’. This resonated with other women’s narratives which indicated that they did not want to be made to feel silly, stupid or embarrassed because they didn't know something. It appears that with this compassionate midwife did not make Jess feel that way. Similarly, with Beryl and Jane below:

‘….she didn’t make me feel stupid, she explained things…..’

Beryl 08 59-60

‘…..the way she managed me and spoke to me, with dignity, treated me with dignity and respect, wonderful, and didn’t, you know, didn’t make me feel embarrassed…..there’s something about, just her manner and that matter-of-factness’

Jane 14 265-272

Being spoken to with dignity and respect and a ‘matter-of-factness’ meant that Jane did not feel embarrassed. The term *matter-of-fact* appeared to suggest a straightforward way of talking in familiar language and that if Jane had been spoken to in a different way she could have felt embarrassed.

Women did not want to feel silly or embarrassed or found wanting. Jennifer seemed sensitive about being made to feel silly or feeling judged. As a younger, unemployed mother, having her second child with a new partner, she disclosed that she felt stigmatised and judged by some health care professionals. Her compassionate midwife didn’t do that. Jennifer talked about how she didn’t feel judged or talked down to by her midwife:

‘…she’s not a person to judge and I think for a midwife to listen is very important because in a way of sort of thinking, they’re there to sort of help you make the right choices for yourself and your baby. So for them to listen and to understand and not judge, I think that’s important especially for a role of midwife and that’s what [midwife’s name] just did’
For Jennifer, a non-judgemental approach, together with listening and understanding her, were the conditions which could empower her to make her own decisions. She later elaborates on this:

‘I feel it’s very important for a midwife to sort of be on the same level…’

Jennifer 17 268-269

Jane appears to be talking about the same sort of quality when she describes compassionate midwives:

‘They’re very humble and they’re down-to-earth.’

Jane 14 328-329

Beryl also talked about her experience of a midwife who was ‘down-to-earth’. During her interview Beryl was asked if she could say more about what she meant by this term:

‘Just not sort of preaching at you, just be a bit more person-to-person just talk eh normally’

Beryl 08 132-135

The phrase ‘down-to-earth’ here seems synonymous with being on the same level or at least not taking on a superior position. Perhaps its opposite would be ‘high-and-mighty’? Beryl’s reference to preaching is particularly interesting because of connotations with moral judgement. It suggests a power relationship in which one person (the preacher) feels qualified and justified to tell another what they should or ought to do. For a number of women in this study, it seems that compassion was shown by midwives whose approach and language minimised the power imbalance within the traditional professional/patient relationship. Women experienced compassion from midwives while being respected as equals, as testified by Jess below:

‘…..she just showed so much compassion but without being patronising…..’

Jess 13 248-249

Above, Jess seemed to highlight that there was a risk of compassion being condescending. Pity and sympathy might be seen in this way and Jovey specifically highlighted this:
‘…..I don’t think compassion is…..I don’t think it’s just pity, I don’t think anyone actually wants to be pitied…..’

Jovey 06 230-231

Jovey was clear; pity is not compassion and should not be confused with it. It is not wanted. Pity implies feeling sorry for somebody, but it often also implies a sense of looking down on that person. Women thought that condescending concern, especially if expressed from a position of moral or intellectual authority was not a part of compassionate care. Compassionate midwives seemed to be characterised by their ability to be just like a normal person as Mary’s experience illustrates:

‘I think it was her positivity and practical support but she did it in a very compassionate way a very warm, human way, she was just a person, you know, I didn’t get a sense of the uniform if you like.’

Mary 04 43-45

Similarly, Mary alluded to the supportive care she experienced which was without an air of professional authority and more person-to-person. Although in the case of Mary’s midwife, while it was assumed that she was wearing a uniform, her approach gave no ‘sense of it’. Reference to the uniform may be significant here as a uniform symbolises professional power and identity and serves to maintain professional boundaries (Shaw and Timmons 2010) and in this way marks the wearer as being something more than just a person. This also raises the question of whether some midwives are seen as hiding behind their uniform because it allows them to be the professional rather than their authentic selves.

Some women felt compassionate midwives were not just on their level but on their ‘side’. When Jovey reflected on the care she received from a midwife after her first son was stillborn she says:

‘I guess I felt like she was on my side…..’

Jovey 06 56-58

The phrase ‘on my side’ implies the existence of opposing sides or an adversarial relationship. Being on the woman’s ‘side’ was a feature in other women’s accounts, for example Helen:

‘I just think, especially with a first child you want to feel that there’s somebody else there and they’re kind of sort of on your side and looking
out for you as well and giving you the support that you need and I felt that I really, really received that and I think I was really lucky.’

Helen 09 225-228

When Helen talked about the midwife being on her side it went beyond a caring role; suggesting an allegiance or loyalty to her. There was no sense of the professional/patient divide but a kind of solidarity. This has similarities to Katrin’s words:

‘I think that’s what compassion is……devoting themselves to try to walk the path with you…’

Katrin 12 145-147

Katrin sees the compassionate midwife as devoted, again suggesting a profound solidarity with her, but for Katrin the midwife was not just on her side but walking her path.

Implicit in this is the idea of the pregnancy, birth and transition to motherhood being a journey. For Katrin the compassionate midwife was prepared to go on that journey with her because of her devotion, giving a sense of a strong commitment to the woman and her individual path.

This theme was characterised by women’s experiences of interactions with midwives who were ‘on their level,’ ‘on their side’ and walking their ‘path’ with them. Such midwives were able to minimise the traditional power relationship through a human (rather than a professional) approach and language that came from a position of equality and respect. This appeared to help women feel more comfortable and more empowered.

6.7 Theme Five: Balance

For some women, compassion was experienced through the midwife’s ability to balance contradictory or competing factors around childbirth and maternity care. Three emergent themes represented the three areas discussed:

- Familiar and unfamiliar
- Mother and Baby
- Individual and the System
Each emergent theme appeared very different initially, but on closer inspection each deal with two potentially conflicting entities. Women’s stories reflected midwives ability (or sometimes lack of ability) to navigate these in ways that they saw as compassionate.

6.7.1 Familiar and Unfamiliar

Birth is a huge life event for a woman, as Helen, Jennifer, Imogen and Louise’s words below testify:

‘…..it’s such a massive experience having a baby you don’t know what to expect….’

Helen 09 31-32

‘….obviously you’re going through such a huge thing….’

Jennifer 17 359

‘…..such a crazy time……especially a first-time mum…..’

Imogen 10 240-241

‘…..the most terrifying situation you probably ever been in in your whole life.’

Louise 01 176-177

However, while birth was described as being an extraordinary life event in a woman’s life, it is witnessed every day by midwives. Louise sums up this situation:

“….by the time I left, er completely overwhelmed by everyone’s kindness and that these people were like angels that’s how I would describe. How you can go in and have such a huge life event and it’s all in a day’s work for these people and it really is quite remarkable!”

Louise 01 181-185

This quote speaks of how unfamiliar birth is for Louise. For her it is a huge event, yet for midwives birth is just part of their work. Louise’s words indicate a sense of mystery and even a spiritual element (like angels) involved in witnessing the everyday miracle. She sees that for these midwives birth is both ‘remarkable’ and routine. She appears intrigued by how midwives navigate this contradiction and do so with kindness.
Imogen’s words above seem to go straight to the heart of this contradiction. She recognises that, on one level, it’s just a job for a midwife and yet on another, it is a ‘really big deal’. Her plea is for midwives to remember this. Imogen implied that she wants midwives to hold this in mind so that they remain aware of how momentous and extraordinary childbirth can be for women.

Women in this study appeared to find it helpful when midwives attempted to familiarise the unfamiliar and they included examples of this in their descriptions of compassion from midwives. For example, Matilda, who was familiarised with her birth environment, and some of the midwives who worked there, before her birth:

‘All the dealings we had with the birth centre were very good, even just the looking round. Eh just phoning up and they going “Yes fine just come in” and taking the time to go through and show us all the different rooms and I think they stopped and made us a cup of tea. They went “Do ya wan a cuppa tea? Come on we will have a sit down and we will have a natter and talk through what you guys fancy”. So that when we went in we were very confident about going into the unit em because they had already taken that time with us to do that which was really nice’.

Matilda 03 113-120

Matilda’s experience familiarised her and her partner with the birth centre where she planned to have her baby. During her interview she gave the impression that she found this very reassuring. It started from the moment she phoned up. The familiar and welcoming manner of the birth centre staff was evident to her. When they were shown around there appeared to be a sense of it being an everyday event involving a ‘cuppa tea’ and a ‘sit down’ to ‘natter’ and this established the birth centre as unintimidating. Moreover, talking through ‘what you guys fancy’ suggests a woman-centred service which is flexible and focussed on women’s choice. Although for Matilda this was a visit to an unfamiliar place in which she would experience a very significant and unusual event in her life, it seemed very different to a formal ‘tour’. Matilda’s words indicate that the midwives and other staff succeeded in giving the birth centre an informal and familiar quality. This was seen as compassionate care to Matilda because it was what helped her know the previously unknown and that helped her feel confident about going there to give birth.
The act of offering and drinking tea was a topic discussed by seven of the women in this study. Tea seemed to be a symbol for a number of aspects related to compassion from midwives and has already been noted previously in this chapter. However, it is within this theme, Balancing the Familiar and the Unfamiliar, that it is perhaps most persuasive. Matilda was offered tea when she went to look around the birth centre and below her words convey the significance of tea and toast after she had given birth:

‘…..after [baby's name] had been born and she was just really, really lovely and she was like “You'll be starving won't you? Come on let's get you some food. I can do you toast like now-now and get you a hot meal. Do you want some toast to keep you going?” So again she didn't need to do that and we got brought a pot of tea, we didn't just get a cup of tea, we got brought a pot of tea with cups and saucers and this massive great big stack of toast and that just kept coming and “can we get you another cup of tea?” ’

Matilda 03 408-419

Matilda, like a number of women, talked about the tea and toast that was offered after birth. Matilda had just given birth, a physically and emotionally demanding process, and what the midwife offered next was tea and toast. It is so ordinary it is almost surprising and yet Matilda’s words reveal something of the meaning that it had for her. It seems noteworthy to Matilda that it was not just a cup of tea but a pot of tea with cups and saucers. Her words evoked a picture of the friendliness, care and time taken to do this. There was also a sense of the grounding effect of the familiar ritual of tea-making and its presentation. The ‘stack of toast that just kept coming’ suggests a generous and abundant outpouring of something very familiar and comforting as a compassionate acknowledgment or response to a woman and her partner coming through an unfamiliar event: childbirth. This was echoed by other women:

‘It was constant tea and that just means so much to us like being offered something like that all the time......I don't know whether it's because we're British? ......It's just the one thing that stuck with us and we were like ‘is that something they're taught to do?”. Because that's such a lovely thing, and the midwife goes off and makes it for you, they don't call somebody else to make it.....yeah, the tea thing, I don't know, I don't know are they taught that? Or is it just certain midwives that just have that? Like when I was sat there just been brought in by ambulance and she said 'do you want a cup of tea?' I was like er I didn't but now I feel so much better that you've asked me! It just calmed me, it was weird, really strange, really strange, erm yeah its comfort, it is a comfort thing really'.

May 11.2 67-109
May’s words, like Matilda’s, revealed how powerful the act of offering tea was for women. May had admissions to the hospital in her pregnancy and was also re-admitted in the postnatal period after she had an episode of bleeding. She reflects on the ritual and recognises the cultural significance: is it ‘because we’re British’? There is a sense of her not understanding how this ‘tea thing’ works. She wondered if midwives are taught it. It seemed important to May that the midwife made it herself perhaps indicating it is a special midwifery skill. Is May suggesting that there is something special about the tea midwives make? She was unsure if it is ‘something’ that some midwives ‘just have’, possibly hinting at an instinctive or innate quality. Such is the power of a cup of tea in May’s experience. Just the offering of tea is a powerful intervention for May, who feels ‘so much better that you’ve asked me’. Tea does not seem to be just tea. For May and for other women in this study it appeared to be a symbol of compassion with familiar yet powerful calming and grounding qualities.

Faith’s experience of compassionate midwifery also involved tea and toast and her description of what happened and the way she makes sense of it was moving and emotional. Below she explains how her midwife cared for her immediately after the birth of her baby in hospital:

‘…..[the midwife] said “Oh I’m gonna let you just sit and recover for a bit erm till you get some feeling back from the epidural” you know “Cuddle your baby, I’m gonna go and get you some tea and toast and I’m gonna run you a bath” and I almost just burst out crying! Cos I just thought you’re just so kind and you’re really looking after us here …..I’m almost crying just thinking about this actually [tearful]….: Yeah, it’s such an emotional thing and it’s a relief and you feel exhausted and your bodies you know been through this massive thing, you’ve met your baby and your hormones are everywhere and then you’ve just got someone who’s just kind of looking after you and just making you feel relaxed and enjoy that moment with your new baby which is like one of the biggest moments of your life. So and its, its so silly but you know, I’ll remember, I’ll always remember the tea and toast and the bath….. [tearful]. It’s like you’ve gone through this massive journey and now you can have a few minutes and just relax and it’s all over and everything’s OK erm I: Almost like that homely type thing? Yeah and its not a medical thing, it doesn’t [pass a tissue to her] Oh thanks. Cos everything’s so highly medicalised when you have a baby and that’s kind of the human thing afterwards and it, and I don’t know why, it always tastes better in hospital, toast just tastes better [laughs] but I think it was just because my midwife kind of picked up on, you know, how I was feeling or how people feel after they’ve given birth…..

Faith 15 126-169
Faith understood that she had been through a ‘highly medicalised’ and ‘massive thing’ which left her feeling emotional and exhausted. Her midwife offered something very familiar and ordinary: tea, toast and a bath and in doing so used the familiar to comfort and ground her. Tea and other home comforts were used as symbols of familiarity and comfort in unfamiliar circumstances by midwives, and women saw this as a part of compassionate care.

Humour was sometimes used to increase familiarity. Some women (Louise, Lisa, Mary, Jovey, Jessica, May and Jane) described humorous interactions with midwives as a part of compassion:

‘I think it’s the humour as well. A sense of humour with compassion, you know, that humour.’

Jane 14 384

Lisa also talked about humour as part of a compassionate approach. She made reference to how humour was helpful for her and her husband:

‘….she was able to make me and my husband laugh and really put us at ease…’

Lisa 02 165

Humour was evident even when there had been previous tragic events and when it might be assumed great sensitivity was needed. It seems that some midwives could judge this well and use humour to good effect, as in Jessica’s experience below:

‘…she knows where we’re coming from so she knows that I can ask questions that actually relate to my personal circumstances having had the death of a baby and probably being over, over worrying in a pregnancy ……. so she could handle that very sensitively and very reassuringly without making me feel that I was over-worrying or over-playing the circumstances. It was yeah just very easy and she comes in and laughs and jokes with us and you know, my husband’s Welsh so there’s a bit of English and Welsh banter going on and it’s just lovely, she’s fab.’

Jessica 07 167-176

Jessica’s midwife already knew her and her husband (from previous pregnancies, including the stillbirth) and it was evident that this continuity was invaluable as a means of understanding the family and their needs (‘she knows where we’re coming from’). It may also have been an important factor in the appropriate use of humour which could
have risked causing offence. The fact that the midwife came to the house may also have helped make the situation more familiar and relaxed. Seemingly, Jessica’s midwife, on the one hand, dealt very sensitively with unusual circumstances (heightened anxiety due to Jessica having had a previous stillbirth) and on the other she balanced this with apparently well-judged humour and banter. This humour and banter served to connect to Jessica and her partner in a natural and familiar way. There appeared to be simplicity and intimacy in this humour which helped make such appointments ‘easy’ despite the difficulties and Jessica’s level of apprehension about her pregnancy.

In contrast, Mary’s experience of humour was during a postnatal home visit and from a midwife that she had not known previously. It could be argued that perineal trauma is not an obvious subject for humour. However, Mary’s words below are another example of how well-judged humour can transform a highly personal and potentially awkward subject into one which is more familiar and easy to discuss:

‘….she actually wanted to hear about my birth and about my stitches and asked “Do you still feel like your body’s about to fall out of you?” you know, she just talked about it in a very normal way and again a bit of humour which was helpful for me…’

Mary 04 157-159

Despite perineal trauma being an unfamiliar, uncomfortable and potentially alarming experience for a new mother like Mary, the midwife’s words testify that this is not unusual in her experience and that she knows how it feels. Mary finds the use of humour in these circumstances ‘helpful’. It goes straight to the unfamiliarity (and perhaps absurdity) of feeling like ‘your bodies about to fall out of you’ in a way that is both graphic and amusing. Mary seemed pleased that the midwife wanted to know how she was feeling after her birth and her words above suggest that humour aided a frank and ‘normal’ conversation around her experience of perineal trauma.

6.7.2 Mother and Baby

Women noticed how compassionate midwives were able to balance care for them and their babies. This was particularly (but not exclusively) applied to the postnatal period. During the antenatal period there is no physical separation of mother and baby and the baby is part of the woman’s body. However, following birth women sometimes felt a change in approach with the baby becoming the focus of care to the exclusion of the mother’s needs. Maree’s words below highlight this:
‘…..so they’re obviously focussed and concerned (I guess) about the baby but it almost seems like the mum gets a little bit rejected at that point, whereas what I kind of define as compassionate midwifery is that they’re caring so much for mum as well as baby you know and at the same time um …..it’s a team……obviously my baby’s the most important thing ever, but you know, right now to make sure that baby stays OK, I’ve also got to be OK so yeah so it is about kind of like looking at mum and a baby as a team, so that’s definitely, definitely something I would say is a part of compassionate care’.

Maree 05 81-99

Maree’s experience was that once the baby was born the midwives focussed on the baby and that the mother was ‘rejected’ rather than approached as ‘a team’. Maree explains that her baby is of paramount importance to her but her baby’s wellbeing is also inextricably linked to her wellbeing. Her words seem to illustrate the mother and baby as a dyad and her view that compassionate care must approach mother and baby as a symbiotic pair. Her experience of not receiving such care left her feeling rejected. In contrast to Maree’s experience, Helen did not feel this rejection. She relayed her experience of care in the postnatal period in which she remained the focus:

‘I was quite surprised cos I thought it would be all like about him, but it wasn’t, a lot of it was about me and how I was feeling and how I was coping and was I alright and was there anything they could do and they always said, you know, ‘ring me if you need anything’, you’ve got the numbers for er [name of ward] and for the community midwives, so I was quite surprised about the amount of support that they gave me. I thought it would all be about him really, so that was quite refreshing and really nice, yeah. So I felt nice and supported at home…….’

Helen 09 184-193

Although Helen was expecting the focus to shift to her baby, she appeared pleasantly surprised at the continued concern for her wellbeing which she thought ‘refreshing’. Helen’s use of the word ‘refreshing’ here suggests that she had not found this to be the case with everybody. It is not clear if this had been healthcare professionals, relatives or others but there is a hint that a focus on her was not universal. Nevertheless, when she did experience it, she seems to feel that it contributes to her feeling ‘nice and supported at home’. Mary’s experience of care in the community once at home picks up on the same theme:

‘…..she was the person most interested in how I was, she asked very little of [baby’s name]….. really but the focus was very much on me
rather than [baby's name] which was different from the majority of people....'

Mary 155-164

As with Helen, Mary remarked on how the focus was on her, and that had not been her usual experience. Imogen also noticed the way that her midwives balanced an interest in her baby with an interest in her:

‘.....she was obviously very interested in the welfare of my child but also me and that did come across....’

Imogen 10 286-287

This approach to mother and baby seemed to be particularly appreciated if there was a problem or particular concern about the baby. When Louise’s baby was diagnosed with a heart murmur and she was told that he might require surgery, it was the extra concern for her and her partner that Louise remembers:

‘.... she was very kind especially er when we found out he had a little heart murmur an er that was quite a shock cos obviously you don’t want to find out anything is wrong with your precious little one when they’re one day old....I remember this midwife came and sat with both me and my partner afterwards and told me about her own daughter and her experience and she has a heart murmur as well and when it was picked up and just talking in general terms about how er you’ll always worry ..... she was very much trying to reassure us um and it did, um it was very kind of her to open up in that way and it did certainly help put things in perspective for us ...... it happens to people and people cope – and I remember she said “you think how on earth will I cope but you will just get on with it and you will just cope cos that’s what they need you to”. That’s a different type of compassion.....'

Louise 01 73-91

Above Louise recalled how at a time of great concern this midwife took the time to sit with them and openly share her personal story with them. There is a sense that this was not a professional conversation but one in the spirit of mother-to-mother or parent-to-parent. Louise describes how the midwife reflected on her own doubts about how she would cope, but also that ‘you do’ cope because that is ‘what they need you to’ do. There is something of an unspoken acknowledgement in these words that the parent’s path is now linked to their baby’s and vice versa and that situation is fraught with worry (‘you’ll always worry’) but at the same time it is normal. The midwife is positive about how they will be able to respond to their baby’s needs and cope with this. This extra attention and support for Louise and her partner was reassuring at a time when there
was something ‘wrong’ with her ‘precious little one’. In responding to their parental distress in this way, Louise recognised this midwife as showing ‘a different kind of compassion’.

Similarly, Katrin’s compassionate midwife also appeared to understand that mother and baby’s wellbeing is highly connected. There were concerns for Katrin’s baby when breastfeeding was difficult to establish and he had lost more than ten percent of his birth weight. However, a significant factor in getting over this problem appeared to be the attitude of the midwife:

‘……the midwife said to me, “you know it’s more important that you’re healthy and that you stay sane, rather than actually having the milk. You know and if it comes, good, then if it doesn’t come, that’s still OK but let’s try to do what we can do best with the situation”. She went day-by-day er what I could feed her, how much, how long - and er then she came and checked it and how am I doing and “how did that go?” Things started to improve and then her weight came back to normal. She came a few times and ………she cared, she cared for me and for the baby.

Katrin emphasised the midwife’s words ‘you’ and ‘your’ health which suggested a significant move from a focus on her baby’s health to her health as a means of dealing with the feeding issues. Moreover, it was not that Katrin’s health was important too, it was ‘more important’ suggesting that Katrin was the most important aspect of her baby’s life and her physical and mental health (staying sane) would be the most important contribution to her baby’s health. Katrin’s narrative suggests that it was this ongoing focus on her own care, as an indirect way of caring for her baby that led to the subsequent improvement and weight gain in her baby.

6.7.3 The System and the Individual
Most women acknowledged that midwives are part of a maternity care system and have many others to care for and many organisational requirements to fulfil. Some women were quite empathic with midwives concerning this potential conflict between care of the individual and the needs of the big system they worked in. Women described compassionate midwives who appeared to balance this well and they also described experiences with uncompassionate midwives who were unable to show compassion under particularly demanding circumstances. Perhaps, because time was seen as a precious resource, in short supply, sometimes time seemed to be seen as a
special gift from midwives. As such it appeared to be a symbol of compassion.

Conversely, lack of time, as a barrier to compassion, was noted by Jovey and Matilda:

‘I think it’s a barrier to compassion if you know if people are more spread out then erm between patients then er they don’t necessarily have the time, as much time…’

Jovey 06 207-209

‘I think for them it wasn’t that they weren’t compassionate people but they just didn’t have the time to give you that kind of level of interaction.’

Matilda 03 426-427

However, Beryl and May talked of their experience of midwives who were compassionate even when busy:

‘….she took time even though she was obviously very busy erm, so yeah I was really impressed by her…… she actually took time to come in and sit down next to me and talk to me…..’

Beryl 08 58-60

‘I knew they were busy and running around and everything, it just like, it just felt like you were important….’

May 11.1 58-59

This appreciation of midwives who somehow managed to be attentive even when very busy, as highlighted in Beryl’s and May’s words above, was echoed in Lisa’s and Jess’s words below:

‘…..the day I gave birth they were really, really busy and um they are just trying to worry about logistics and stuff like that and you can really feel it and yet some people worry more about the person’.

Lisa 01 52-54

In contrast, for Lisa there seemed to be a palpable difference between people who were concerned about ‘logistics’ and people who are concerned with ‘the person’.

However, Jess’s words below, while very positive about the compassionate care she received, hint at a potential risk when it is busy:

‘….there was a lot of compassion shown there……These guys were rushed off their feet but you never felt like you were a burden, they really were great.

Jess 13 73-74
Jess’s words suggest that feeling like a burden was something that could happen when staff were busy and Maree recalled an experience which made her feel just like that:

‘I felt like I was a pain to her like I was just a burden on her workload and that she had lots of people to look after,….’

Maree 05 304-305

As Jess’s and Maree’s words indicate, women seemed very aware of the effect of workload on midwives and the care they provided. Student midwives, featured in many women’s stories of compassion. Student midwives may have more time to spend with women because they are supernumerary (extra to the normal staffing levels) and work under the supervision of a qualified midwife. Women appreciated the extra time that student midwives had to give to them. Imogen’s experience is a good example of this:

‘The time element allowed the student midwife to really go into detail, ask me questions, feel like she was empathising with me whereas I kind of felt a little bit like I was on a conveyor belt with the other midwife, so there wasn’t that level of empathy and I think compassion, she had to get through her workload and she had to get through her paperwork’

Imogen 10 167-173

Imogen noticed that this student midwife had more time for her and less paperwork than the qualified midwife whose care resembled a ‘conveyor belt’. Here Imogen seemed to capture the concept of throughput. The need for throughput is a feature of any busy maternity unit that is serving a whole community. Without throughput the system will grind to a halt. The qualified midwife had work to ‘get through’ and this made Imogen aware that she was part of throughput. The student who had more time could concentrate on her as an individual.

Women noticed that midwives had to juggle other organisational requirements with women’s clinical and emotional care. As with Imogen above, administrative and record-keeping requirements featured in women’s accounts. Seven women (Louise, May, Matilda, Imogen, Beryl, Jovey and Katrin) talked about how these contributed to an experience of ‘tick-box’ or processed care and how this was not consistent with compassionate care. This is exemplified in Mary’s experience when she was discharged from hospital:

‘…the day I was discharged em, because I saw ten professionals the day I was discharged, one after another after another and all of them bombarded me with information, forced leaflets at me em got through
their auditing tick boxes and left and I honestly felt, having the labour that I did and a baby twenty-four hours old er, you know, being up to my eyeballs on pain relief and antibiotics, em, I felt like a human tumble-drier I really did..... it was just like relentless er one after the other after the other erm, and all of them were very tick-boxy it was 'I've got to disseminate this information and some of them actually said that. They said "Sorry we've got to chuck a lot of information at you but we have to" and then proceeded to chuck it at you.'

Mary 04 192-203

Mary’s account evoked a vivid picture of attention from a variety of health care professionals, including midwives. She remembered how she was bombarded with information and leaflets which were ‘forced’ on her or ‘chucked’ at her. Mary described being a passive recipient of an onslaught of activity which she believed to be governed by ‘auditing tick boxes’. At a time when she perhaps needed compassion (she listed her difficult labour, analgesia and antibiotics to illustrate her situation) the activity she experienced seemed designed to meet the system’s needs but not hers. On the other hand, in contrast to this experience, Mary later described how during a postnatal home visit, her needs were balanced with the needs of the system:

‘.....although looking back she did obviously go through, cos she did have to audit a few things on that visit..... it didn't feel like that er the paper work wasn’t out, she did all the paperwork at the end erm, she said to me, she was quite apologetic really......she said “I'm really sorry I'm just going to have to write these things while its fresh in my mind but I'd rather do it at the end" erm so you know I had no worries about what she was writing or you know about what that was all about and the focus was all on me, it wasn't two sentences and onto the computer....’

Mary 04 155-164

On this occasion despite having to ‘audit a few things’ and complete her records, Mary was still the primary focus of the visit. This suggests that the midwife had devised a woman-friendly method of balancing these competing needs which worked well for Mary. By leaving the record-keeping until the end she could talk to Mary without interruptions. Mary refers to others who attend to record keeping in a different way (‘two sentences and onto the computer’) with the implication that this was not a good experience for her. Imogen and Jess’s words below appear to concur that while they understand that midwives have organisational demands to tick boxes and collect information, this can be balanced with a woman-centred, friendly approach:

‘.....you have to tick certain boxes and make sure but I don't know if there's another way it can be done that doesn't feel like a tick-list?'
Maybe more patient led? Than, I know you’ve got to go through, you’ve got to say certain things, but I think there’s ways you can phrase a question. So rather than reading it out, I donno, making it more conversational than just kind of like a script.

Imogen 10 426-431

‘….she was just very jolly, very chatty, chatting to me about her family, her children and her experiences and whatnot and making links with mine and asking about my other children, child erm but in doing so, you could tell she’d gathered all the information she needed to gather and how steady I was on my legs, whether I’d passed water or not. So she’d get in everything she needed to….’

Jess 13 251-256

Women also sometimes talked about how compassionate midwives could balance their individualised care needs with hospital guidelines or rules. Louise’s words below are an example of this:

‘……she’d weighed him and he’d lost quite a lot of weight, erm, it was eleven per cent and she said she er had to phone it into the hospital if its er above ten per cent and she did…..the doctor was of the school of thought that they should take him in because you know the rule is that if they’re ten per cent, thats the cut-off point……therefore you should bring him in cos that’s what the books say whereas [midwife’s name] was of the school of thought that otherwise he is well, happy and vital signs all there and mum is establishing breast feeding very well at home and it would be in [our] interests to keep him at home……it’s that sort of discrepancy between the clinical sort of approach and the experience, maturity approach and I could pick up on it straight away…..I think that type of experience and that type of not just experience but a certain type of maturity is priceless, and so I do think that some elements of compassion come with that…..’

Louise 01 268-290

Here Louise highlighted the difference between the doctor, who thought that they should follow ‘what the books say’, and her midwife who was aware of these but balanced them with Louise’s and her babies ‘best interests’. Louise also recognises that to balance these two positions requires experience and a ‘certain type of maturity’. There is an impression of the midwife adopting a holistic approach rather than following a rule and of also having the experience and confidence to challenge the standard practice. Louise went on to confirm that her baby was not admitted to hospital and in conjunction with regular support from this midwife gained weight and progressed well.
6.8 Theme Six: Compassion Made a Difference

This theme emerged from the ways that all of the women in this study (17/17) identified that compassionate care made a difference to them. They described it as helping them feel better. Compassion made them feel safer and it made them feel more able. Women related these benefits to their need for compassion as described in the theme: Women’s Need for Compassion, and their experience of compassion from midwives as described in the preceding sections of this chapter (sections 6.4, 6.5, 6.6, 6.7). For this reason, this theme can be seen as an emergent theme of all the superordinate themes. Nevertheless, at a conceptual level it stood as a distinct theme as it demonstrated convergence across most women participants. Furthermore, it illustrates the effectiveness of midwives’ compassionate response to women’s needs and represents the perceived benefits of compassionate care for women in this study. These topics will be discussed further in the following chapter. Therefore, ‘Compassion Made a Difference was preserved as a stand-alone emergent theme which warranted some focussed attention of its own.

Thirteen women revealed how they felt safer and less anxious as a result of compassionate care from midwives. It is known that anxiety leads to feeling unsafe and feeling unsafe leads to anxiety. The majority of women in this study (11/17) described compassion from midwives in the context of their anxiety. Many examples of how midwives responded to women’s anxiety have been illustrated in Section 6.3.3 of this chapter. Below, Louise also spoke of feeling safer:

'I felt completely supported and safe actually the whole time I was there, um which given the nature of what you’re going through, to feel completely safe is quite remarkable actually, given , you know, the fact that you’re giving birth and it’s the first time and you don’t know what’s happening .....to feel safe in that situation, which is the most terrifying situation you probably ever been in in your whole life, you need to know that you can trust the people around you and that they have your best interests at heart’

Louise 01 322-326

Louise had previously referred to her history of anxiety and feeling very anxious and vulnerable about birth. Yet her words above expressed how the care that she experienced led to feelings of trust, safety and support. As she reflected on this there was a sense of her feeling that it was surprising and even impressive ('quite
remarkable actually') that she was able to feel so completely safe despite the huge potential for feeling terrified.

Mary also relayed how compassionate care had increased trust, and she contrasted this with her experience of a lack of compassion at one of her postnatal appointments. She recalled the interaction and how she was asked questions about postnatal depression:

,…..she was really, really blunt and abrupt and it was such a closed question and I thought well if I was depressed I sure as hell wouldn’t talk to you about it, you would have been the last person I wanted to have talked about it’

Mary 04 243-246

The issue of trust and safety appear paramount in this example. Mary was sure that a lack of compassion would have prevented her from disclosing a problem. This view was raised by other women and seems to relate to lack of trust. Similarly, other women made a link between compassion and increased trust. Esme:

‘I think one of the other differences with those compassionate experiences…..was that I think I trusted [name of compassionate midwife] more….’

‘Esme 16 138

When women trusted midwives they felt safer, and Jane had specific ideas about which midwives she felt safer with:

‘I feel more safe with them, the more experienced ones….. I felt they were more maternal with me, more nurturing with me….’

Jane 14 110-113

Jane felt that her compassionate midwives had been the more experienced midwives and that, to her, their experience and compassion were linked. The key for her was these midwives made her feel safer. An experienced (and perhaps older) midwife appeared to meet Jane’s safety needs. She had previously disclosed her feelings of vulnerability and fear about birth and her need for nurturing. As already seen in Section 6.5.4, some women talked about younger and less experienced midwives and student midwives being more compassionate. Despite the variety of opinions on the
ideal characteristics of the compassionate midwife, the link between compassion and feeling safer and less anxious was common.

Compassion from midwives also appeared to influence women’s feelings of being able to cope, and confidence in their abilities. This was most often discussed in relation to the postnatal period. When women felt empowered this appeared to increase coping and confidence and this was explored in Section 6.6.

Although trust has been described in relation to feeling safe by some women, trust also seemed to make a difference to women’s confidence and coping feelings. Imogen’s words exemplify this:

‘I think probably the biggest thing was confidence so with the student midwife I felt confident in that what I, if I was struggling I could speak to her about it, press the buzzer do those type of things. I wasn’t going to be a nuisance, she would come back to me, support me and give me the time and the support that I needed…..I didn’t feel like I could approach the other midwife…I suppose that probably is what it comes down to, providing that relationship and making sure that a person’s approachable, it really helps bridge that gap and instil confidence then in what you’re doing….’

Imogen 10 196-226

Imogen’s trust in a student midwife’s availability, approach and support helped her feel more confident with breastfeeding and caring for her new baby on the postnatal ward. Similarly, Jess’s experience also makes a connection between compassion and confidence:

‘…..cos you go home in a positive state of mind don’t you? If I’d had an awful experience and felt I wasn’t shown any compassion I would have started on a low ebb, cos my confidence would have been in my boots cos you just think ‘oh I can’t even give birth properly, let alone look after this child’ but not just that, the confidence was given to me about breastfeeding……I went home on cloud nine’

Jess 13 467-480

Above Jess relates the compassionate care she received to her positivity. There is a sense of her feeling confident in her ability to go home and care for her baby. This appeared to have a big impact on her mood and general wellbeing as she ‘went home on cloud nine’. There is also recognition and acknowledgement that it might not have been like that if her care had been different. In different circumstances she would have felt less able to cope.
The difference compassion made to self-efficacy and confidence is illustrated in Faith’s comparison of her two births:

‘…..with this second birth I came back home feeling on top of the world and I had, even now I just look back and I feel so happy….. I was just so overwhelmed with how good they were. So it’s a massive, positive thing for me this time, whereas last time I wouldn’t of dreamed of writing a thank you card or anything like that cos I couldn’t even re-visit it and I wanted to forget, how that experience…. But I think it certainly affected how I got on with [name of new baby] in the first few weeks. Not, not the feelings towards her but just how I could cope with looking after her if you know….. I felt like I could, I felt so happy to talk about the birth and you know to have visitors over and to have like a really lovely first few weeks with her and just enjoying her whereas with [her first baby’s name] I think I was so traumatised about what happened I didn’t really want people to come over to talk to me about it…..I didn’t really feel that confident in what I was doing, I felt a bit rubbish in myself….. I guess it’s kind of slightly tainted with the fact that second-time mums may feel more confident anyway cos they’ve already had a baby so they do know a bit more about what they’re doing. But then I think they also know what good care and bad care is cos they’ve had time to process whether it was good or bad with their first one. They’ve had experience either way erm…..yeah so this time I was able to say with more confidence that the first time was bad and the second-time was great, purely in terms of compassion in care’.

Faith 15 388-427

Faith had explained her compassionate midwifery care in detail and the difference it made to her was evident. She acknowledged that many second-time mothers do feel more confident, but indicates that there is more to it for her. Faith argues that having had two births, she felt in a position to compare and judge the care she received because she knows ‘what good care and bad care is’. She recalled how she went home from her second birth feeling ‘on top of the world’ and how different this was to her first birth. Faith’s narrative portrays her experience of receiving compassionate care and its impact. To Faith compassion was the factor that influenced her mood positively in the postnatal period and increased not just her ability to cope with, but to enjoy, her new baby.

6.9 Summary of Findings

In this chapter the themes that arose from the analysis of eighteen interviews from seventeen women participants were presented. Six themes consisting of five superordinate themes and one stand-alone emergent theme represent the findings in their entirety. The first superordinate theme: Women’s Need for Compassion presented
the context in which women experienced compassion from midwives. This theme revealed the reasons why the women in the study felt they needed or wanted compassion at the time. Themes two, three, four and five were superordinate themes which represented women’s experiences of receiving, what they considered to be compassionate care from midwives. These were: Being with Me, Relationship, Empowerment and Balance. The sixth theme: Compassion Made a Difference showed how the experience of compassionate midwifery care made women feel safer and more able. These themes and the relationship between them have been summarised and depicted in The Model of Study Findings in Figure 6-1. Discussion and interpretation of these findings, in relation to the research aims and the wider literature, is presented in Chapter 7.
Figure 6.1: Model of Study Findings: Women's Lived Experience of Compassion from Midwives
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Table 6.2 Superordinate and Emergent Themes Across All Participants
Chapter 7 Discussion

7.1 Introduction to Discussion

The overall aim of this study was:

To develop a deep understanding of the experience of compassionate midwifery to inform practice, education and service provision and guide future research in this area.

This discussion will focus on how this aim has been achieved. In the absence of any empirical studies on compassionate midwifery, a concept analysis in Chapter 3 and depicted in the model in Figure 3-3 described the nature of the concept within the academic and grey literature. The IPA study then focussed on women’s lived experience of compassion from midwives. The findings presented in Chapter 6 and depicted in Figure 6-1 represent the first study of its kind and a major breakthrough in terms of understanding the experience of receiving compassion from midwives. The ways in which women experienced compassionate midwifery and the impact it had on them has been identified. This discussion will critically consider the methodologies used to this end and limitations are listed in Section 7.10. Importantly, a newly conceived and novel model will be presented which explains the relationship between the elements of compassion, as experienced by the women in this study. Each element of the model will be critically examined to explore how it contributes to existing midwifery knowledge. This study has revealed that compassionate midwifery was an effective intervention for women’s suffering which helped them to feel less anxious and more able. Furthermore, the new model assists in understanding how this intervention works and also lends itself to considering the skills and attributes of the compassionate midwife.

7.2 Compassionate Midwifery: The concept and the experience

A critical discussion point of this thesis is that it employed two very different methodologies to examine compassionate midwifery: an evolutionary concept analysis and an IPA study. Consequently, they provided two different, yet valuable, perspectives which have both advanced the understanding of compassion within a midwifery context. The links between the findings for the concept analysis and the study are represented in Figure 7-1. However, the ways in which they are similar and yet different
are important to understanding compassionate midwifery and are therefore critically debated within this chapter.

Firstly, following the journey of the thesis, it is the researcher’s belief that the concept analysis and IPA study do not merge to form a combined understanding, rather that they complement each other. Unlike a hybrid model of concept analysis which integrates field work (Schwartz-Barcott and Kim 2000:129-159), the model of concept analysis used, based on Rodgers evolutionary model (2000a), stands alone. Therefore, it did not inform the IPA study, a point which will be unpicked further in this chapter in Section 7.3. Nevertheless, the concept analysis facilitated a comprehensive and much-needed professional debate about the current thinking or ‘state of the art’ of the concept of compassionate midwifery (Ménage et al 2017). Paradoxically, an evolutionary model was apt despite this being a new concept. Notwithstanding the lack of scope for looking back in time at the evolution of compassionate midwifery as a concept, it provided a timely, initial analysis or evolutionary starting point. Furthermore, this can, and should be repeated in future research, using the same model, to track the concept’s development over time and within different cultures.

Secondly, to explore the way that compassion is actually experienced by women, the phenomenological approach which underpins IPA, necessitated bracketing off or moving away from the concept analysis and starting anew (De Chesnay 2015) as described in Section 4.4 of this Thesis. This presented some challenges as the researcher made the methodological shift from moving right away from compassion as the conceptual process depicted in Figure 3-1. Instead, curiosity and open-mindedness served to elicit a new understanding by exploring the lived-experience for the seventeen women in this study. While the concept analysis looked outwards for a broad account or understanding of compassion in midwifery, the IPA study was concerned with individual women’s inner experience.

Furthermore, the appreciative approach, used to recruit participants, successfully met the study objective of identifying women who had experienced compassionate midwifery. IPA methodology was well suited to the task of uncovering these women’s personal and unique stories of their experiences of compassion from midwives. Importantly, it was an effective tool in eliciting the depth and breadth within their stories, which could easily have been missed if other, more superficial methods were used. IPA required deep emersion in the data and close attention to individual women’s stories.
which revealed idiographic accounts full of very rich data. The findings are testament to this process. Findings across the group of women were robust because of their grounding in examples of these rich descriptions within the individual accounts.

Arguably, using concept analysis and IPA separately to explore a previously unexplored topic is a somewhat novel approach as no accounts of this combination have been found in the literature. Moreover, by using these two different approaches the research moved back and forth from the general to the particular in a hermeneutic cycle. The concept analysis examined a general understanding of compassionate midwifery, then the IPA study examined the particular by focussing on the unique experiences of individual women. The analysis then moved from the individual women to the general themes across all of the women participants. Crucially, IPA demands attention to the particular to support any general claims, therefore the researcher continued to move back and forth, through what was a hermeneutic process. In this way the analysis stayed ‘true’ to the underpinning principles of IPA: phenomenology, hermeneutics and ideography. As a consequence the findings were robust, credible and most importantly, they met the study aims by providing a deep understanding of the women’s experience of compassionate midwifery as outlined in Section 4.2 of this thesis.

A criticism of this study might be that only seventeen women were interviewed. This is a modest sample size in relation to some other qualitative studies. Yet in IPA, where very small samples of six or less are common, this was a large study of its type. The expected richness of depth of the data and the level of emersion required in the analysis means that IPA is not suited to large groups of participants. Moreover, larger sample sizes can be at the expense of individual depth (Smith, Flowers and Larkin 2009:106). However, in this study, which was part of a doctoral thesis spanning three years, the researcher used time effectively in order to commit to a substantial study. A balance was struck between idiographic focus and the total number of women participants. Importantly the eighteen interviews from seventeen women captured a remarkable range of experiences from women during pregnancy, birth and the postnatal period and a rich level of detail that fulfilled the needs of this study.

Another critical issue in this study was that all participants had received midwifery care from midwives at two NHS Trusts in The Midlands, in the UK. Irrespective of whether they had been classified as having midwife-led or consultant-led care (and there was a
mix of both), all had received care from midwives. While these two Trusts covered inner-city, town and rural areas, women participants only came from the defined geographical areas that these two Trusts covered. Moreover, the participants were predominantly white, professional women. As such they were a fairly homogenous group. Whilst this is an advantage in an IPA study which seeks to understand a perspective rather than a population, it calls in to question the transferability of these findings to other women in this setting who did not participate in the study and for women in other settings. However, while there is a need for caution around generalisability of qualitative studies (Schofield 2002) some aspects of this study would appear to support a degree of transferability and applicability. In particular, this study did achieve replicability of participants because each participant self-identified as having had compassionate midwifery care and felt able to tell the researcher what they thought that was (Polit and Beck 2010). The researcher’s reflexive diary contains entries which reflect on the way women participants seemed to have obvious expertise in this subject:

“I have done four interviews now and all the women seem to be absolute experts on this subject. They have talked in detail about their experiences and they know why they thought it was compassionate and how it made them feel. Feeling justified in my decision to ask women what compassionate midwifery is”.

Entry from the researcher’s Reflexive Journal 08/07/16 (When reviewing the interview process after first 4 interviews)

As the journal entry suggests, women in this study recognised compassion from midwives and felt that they had something important to say about their experience of it. Consequently, this appreciative bias when recruiting women participants, constituted a form of critical case sampling (Patton 2014:276) which harnessed women’s legitimate and specialised knowledge based on their experiences. Therefore, it yielded more relevant information and met the aims of this study, more effectively than a random sample or any other sort of sample could have. Moreover, ‘analytical generalisability’ was enhanced through the careful analysis of thick data which is authenticated by participants’ words (Polit and Beck 2010). Arguably, both critical case sampling and the IPA analysis of participants’ thick, rich descriptions, presented in Chapter 6 strengthen the potential for the understandings from this study to become ‘usable knowledge’ (Thorne 2008:227), enhancing our understanding of compassionate midwifery more generally.
A further critical issue concerns the researcher as an insider (Asselin 2003; Burns et al 2012; Sonya and Buckle 2009). As an experienced midwife who previously worked at one of the NHS Trusts involved, this could have been a means of introducing bias. For example, as a professional, and somebody seen as an expert in this area of care, there might have been a perceived power differential, in which the women participants viewed the researcher as an authority figure and source of authoritative knowledge or in other words ‘the knowledge that counts’ (Sargent and Davis-Floyd 1997:8). As a result, the researcher’s ability to elicit the women’s authentic thoughts and feelings might have compromised this study in two ways. Firstly, the asymmetrical, hierarchical relationships between specialists and patients, inherent in healthcare, might have led women to think that their views were not important or valid. Secondly, women may have felt inhibited expressing any negativity about midwives or midwifery. Importantly, women’s self-censoring, in this way had the potential to undermined this study because although this study sought to understand women’s experience of compassion from midwives, sometimes women make sense of compassionate care through comparisons with care that lacked compassion. Therefore, it was crucial to this study that women felt comfortable to tell their stories through patterns of interaction that felt as natural as possible without fear of repercussions and inhibitions caused by unequal power relations.

However, the potential problems of being an insider researcher were acknowledged and considered in Section 1.4. A reflexivity journal helped the researcher to manage this risk by developing a reflective awareness of her role and the relationship and power dynamics between herself and the women participants. Moreover, being an insider researcher has both potential risks and benefits. Entries in this journal, presented in Section 5.5.4, reflect on the good rapport and the degree of openness between the researcher and participants, which was so crucial to this study. The researcher’s previous experience with women around childbirth enabled this process, which arguably may have been unlikely to have been achieved by a researcher new to working with this client group. Nevertheless, this could be something of a double-edged sword for the researcher who needed to identify as a researcher and not a clinical midwife during interviews. Entries in the researcher’s reflexive journal in Section 5.5.4 testify to some initial difficulties adapting to the researcher role, which necessitated not being able to offer midwifery support in situations in which she would have as a midwife on duty. Occasionally women participants did ask the researcher for information or advice. Although the researcher had a protocol in place to refer women to their
community midwife or other services if a need was identified (Appendix 12.4), the researcher, initially, found this uncomfortable. However, reflection on this, over the course of the first few interviews assisted in this psychological adaptation from midwife to researcher.

The fact that the women participants knew that the researcher was a midwife by profession appeared to enable them to talk openly and comfortably about the intimate details of their pregnancy and birth. Notwithstanding the potential risks of being an insider researcher, during interviews with women, there appeared to be a level of trust which allowed women to discuss aspects of their experiences very openly. Although the potential benefits of being both clinician and researcher are well documented, there are also advantages which support ethical and sensitive interviewing (McNair, Taft and Hegarty 2008; Scerri, Abela and Vetere 2012, Shaw 2010). This appeared to be evident in this study. Women participants discussed personal details such as perineal trauma, blood loss and cracked nipples, which might have been difficult or embarrassing to talk about to a researcher without this background. Moreover, the two women who had experienced stillbirths, talked very openly about them and their significance, although their pain was evident. They appeared to feel safe to do this with the researcher who had previous experience of caring for women following perinatal deaths. Arguably, compassionate interviewing, in which the researcher listened to their accounts of suffering and created a space for them to talk and feedback about their care, enabled this. Notably, in this study women appeared to be highly motivated to tell their stories and to communicate how important compassion from midwives was to them.

7.3 Comparing and Contrasting the Concept Analysis and the Lived-Experience

A critical comparison of the findings of this study and the concept analysis reveals some clear links. In particular, the IPA study themes Being With Me, Relationship and Empowerment map onto the attributes of compassionate midwifery from the concept analysis (Figure 3-3). However, a new, integrated model was considered but judged inappropriate because, as stated at the start of this section, they contribute understandings to different facets of compassionate midwifery. Consequently, although there are some clear similarities, there are fundamental differences between the
concept analysis depicted in Figure 3-3 and the Model of the Study Findings shown in Figure 6-1. These will now be critically discussed.
Figure 7.1 Links Between the Attributes of the Concept of Compassionate Midwifery from Concept Analysis and Superordinate Themes 2-5 from Findings

Attributes of Compassionate Midwifery from Concept Analysis

- Authentic presence
- Recognition of suffering
- Sympathy
- Empathy
- Connectedness/relationship
- Engaging in emotional work
- Motivation to help or support
- Seeking to empower the woman
- Negotiating ways to relieve suffering using shared decision making
- Using knowledge and skills to alleviate suffering in a way that is welcomed

Superordinate Themes 2-5 from Findings

2 Being With Me
- Calm and relaxed
- Communication and touch
- Available and tuned in to me

3 Relationship
- Developed a relationship with me
- Understood me and could personalise my care
- Actually cared
- Like friend or family

4 Empowerment
- Giving information
- Teaching and coaching
- On my level

5 Balance
- Familiar and unfamiliar
- Mother and baby
- The system and the individual
There is a strong argument for comparing Women’s need for Compassion, presented in Section 6.3 of the Findings, to the antecedent suffering (in the concept analysis). This superordinate theme represented the context for the compassion women received and is discussed in more detail in Section 7.7 of this chapter. It has similarities to an antecedent in that it related to what was happening immediately before the compassion took place.

The other antecedents in the concept analysis included the particular approaches and skills (e.g. respect, sensitivity) thought to be needed before compassionate midwifery can happen. However, in the study, women did not talk about these as pre-requisites because they were talking about their experience of compassion when it happened. Therefore although the women interviewed did talk about the approach and the skills of the midwife, it was all part of their experience of receiving compassion. For example, partnership working and a non-judgemental approach were integral to the experience of compassion as empowerment as women explained in Section 6.6.3 of this thesis. Therefore many of the antecedents in the concept analysis emerged as important features of the experience of compassion in the study. Women experienced midwives’ characteristics, values, knowledge and skills as part of their experience of compassionate midwifery and not separate from it and this illustrates the limitations of the concept analysis. Whilst it organised the concept of compassionate midwifery into an object of study, it could not develop knowledge in itself (Risjord 2009). However, by studying the lived-experience, understandings have developed. These understandings have not shown the elements of the concept analysis to be false in themselves, rather that they are experienced in a different way. Therefore the study has been able to set the concept analysis in context and develop understandings about the experience of compassionate midwifery. Consequently, it should make a real and novel contribution to knowledge development on compassionate midwifery.

Another of the study findings centred on Compassion Made a Difference, which also evolved in the concept analysis as consequences of compassionate midwifery. Women in the study recognised that their experience of compassion from midwives helped them to feel better. This was usually in relation to their need for compassion. Women described how compassion made them feel safer and more able to cope. Perhaps, because of this, compassion was something that women in this study looked for in midwives, especially when they felt anxious or distressed. In this way it emerged in the study as an interaction which women sought and valued and which, they believed,
helped them. Arguably it has all the elements of an effective intervention and this point is critically debated in Section 7.7 of this chapter.

Returning to the consequences in the concept analysis (depicted in Figure 3-3), these appear to be more extensive and detailed than the study theme Compassion made a Difference. For example, women in the study thought that compassion reduced their anxiety and increased feelings of trust and safety. Some of the other consequences in the concept analysis were not confirmed by the study because the study was not designed to link compassionate midwifery to birth outcomes or birth memories. Nevertheless, there are suggestions that women did make sense of their own experiences in this way as can be seen in Section 6.8 and particularly in Jess’s and Faith’s quotations. These indicate that, for them, compassionate care made for positive memories of birth and a more positive start to life with a new baby and beyond.

The consequences for midwives, in the concept analysis (improved job satisfaction and improved working relationships) were not, and could not, be addressed within this study on women’s experience. While there are suggestions within women’s stories, of them recognising that the compassionate midwives they describe are more engaged in their work and get more out of the relationships with women, this can only be explored with a study focusing on midwives.

The process of compassion in the concept analysis includes recognition of suffering. At first glance this seems similar to the superordinate theme in the study: Being With Me. Certainly, Being With Me includes many of the features necessary for noticing women’s suffering. Similarly, Emotion as part of the concept analysis process appears to match well to the study finding of Relationship, especially the features of actually caring that women described. However, there is a key difference. In the concept analysis these parts of the process were seen as separate with one leading to the next. Crucially they were considered fore-runners to the motivation to act and the action to relieve suffering. This was not born out in the study. For women in the study their experience of midwives Being with Me and in Relationship was integral to the compassionate care they received from midwives.

Interestingly, motivation in the concept analysis was not represented in the study findings. This may be because the study explored women’s experience only; it reveals little of why or how midwives were motivated to show compassion. Although, arguably, the study’s emergent theme Actually Cared reflects women’s experience and sense-
making around what motivates midwives to be compassionate. Women may have thought midwives were motivated to show compassion because they actually cared. Caring is not just random behaviour. Those who care are motivated or driven to do so, by something. Understanding caring as the emotion which drives caring behaviour provides a window into this complex mystery (Mayseless 2016:35-36). The emotional content of midwifery has been acknowledged, studied and debated in the literature (Hunter, B. 2002, 2005, 2006, 2011; Hunter and Deery 2009, Hunter et al 2008, Hunter and Smith 2009) highlighting the emotional regulation required in woman-midwife relationships. However, the literature does not fully explore the nature of the emotions that may drive their caring behaviour. In this study women seemed sure that compassionate behaviour from midwives was driven by genuine feelings of care. While this provides a credible possibility, it cannot be confirmed in the absence of a suitably designed study of midwives. Therefore it is an important avenue for further research.

Another tension was that one aspect in the concept analysis in Figure 3-3: action (to alleviate suffering) was found to be significantly different in the study. Three themes drawn out from women participant’s lived experiences included Being with Me, Relationship and Empowerment. These themes all highlighted the ways that women needed compassion, in these forms, to relieve or prevent suffering. Collectively, they constituted the tangible aspects of women’s lived-experience of compassion which did not necessarily happen in a linear fashion. As a consequence, the process of compassionate midwifery depicted in the concept analysis, as four separate elements (with each one leading to the next) had similarities but it was not mirrored in this study. Whilst women experienced the interactions with midwives, encapsulated in these three themes, as acts that relieve suffering and therefore as compassion, for individual women these were part of a whole experience and not a process. The theme Being With Me was concerned with the ways that midwives noticed and paid attention to women’s suffering. Key to this theme was that just paying attention to women and noticing their suffering, in itself, appeared to be a compassion ‘action’ that relieved their suffering by helping them to feel less anxious and therefore safer. Furthermore, this noticing was reciprocal as women very quickly noticed if their midwife was doing this (as described in Section 7.4.1). However, this and other aspects of compassionate care (around Relationship and Empowerment) sometimes also happened simultaneously. Compassion as Being With Me, Relationship and Empowerment were
part of the whole experience of compassion and in this study they could blend or occur intermittently within different accounts.

Interestingly, the superordinate theme *Balance* was not found through the concept analysis activities and was not represented in the gathered literature (Ménage et al 2017). However, the part it played in women’s experience seems key to answering the research question: *What is compassionate midwifery from the perspective of women who use maternity services?* It also meets the aims of the study as it reflects women’s thoughts and feelings on compassion. The theme *Balance* emerged from the ways women interpreted and made sense of their midwives’ sense of perspective on birth, life and their role. This appeared to enable midwives to do their job and be compassionate, in the eyes of the women in the study. The way in which *Balance* worked, in conjunction with the themes Being with Me, Relationship and Empowerment in this study will be presented in the following section of this thesis.

### 7.4 Attending, Relating and Empowering

In this study, four superordinate themes: Being with Me, Relationship, Empowerment and Balance represented women’s lived experience of compassionate care from midwives. However, as discussed, they were not aligned to a process, as in the concept analysis. Arguably, they combined in a different way. Being with Me, Relationship and Empowerment represented what midwives did and said and how they behaved towards the women. The theme Balance was more aligned to (what women experienced as) the midwife’s personal or philosophical approach. Balance represents women’s recognition of compassionate midwives’ inherent sense of balance, as something that enabled them to uphold compassionate care. The way in which these four themes worked together is represented in Figure 7-2, below. (A larger version is found in Appendix 12.8)
The Model in Figure 7-2 uses the theory of balance to propose a new, dynamic representation of the lived-experience of compassionate midwifery. This model depicts the relationship between four key superordinate themes which emerged from women participants' lived-experiences of receiving compassionate midwifery. In this model the superordinate themes: Being with Me, Relationship and Empowerment work together within a sphere which represents the midwife’s compassionate care. The lines which separate these three themes within the sphere are not fixed but flexible, to allow adaptation to women’s need. This sphere of compassion could be conceptualised as the sum of the attending, mothering and mentoring that women experienced when they
received compassionate midwifery care. The balance beam represents the complexities, conflicting demands and paradoxes that women were aware of in midwives work. Supporting this, the fulcrum represents the qualities, personal approach and philosophy which women recognised in midwives who were able to maintain the balance required in order to deliver compassionate care. Each of these elements will now be critically discussed in relation to the findings to explore how this model has contributed to an understanding of compassionate midwifery. They way in which all three combined in women’s experiences is also explored. Moreover, the significance of this for practice, education and service provision will be considered.

7.4.1 Compassionate Midwifery by just Being with Me

Women in this study experienced compassion in the way that midwives demonstrated attentive presence and this has been illustrated in the finding: Being with Me in Section 6.4 of this thesis. These findings support the literature on midwifery presence and attentiveness (Berg et al 1996) and build on this by providing new contextual details about how and why women experience this as compassion. Women experienced compassion from midwives who were physically and emotionally present and attentive. The phrase ‘tuned-in’ encapsulates this quality. Tuning-in appeared to enable midwives to notice what was really going on for women. However, this observation appeared to be quite different to purely clinical observation. Whilst clinical observation was not excluded, women did not seem to get a sense of the ‘obstetric gaze’ (Davis and Walker 2010) which seeks to observe, measure and document women’s bodies in relation to medical parameters. Midwifery attentiveness, experienced as compassion in this study, might be described as a holistic or humanistic gaze of the woman as a unique person in herself, in her body and in the world.

One of the most notable aspects of women’s experience of compassion in this study was the speed with which women recognised whether a midwife was ‘tuned-in’, or not. There was something about the way that the midwife was with the women that was almost immediately recognised, suggesting that it was not only the midwife who was ‘tuned-in’ to the woman but the woman was also ‘tuned-in’ to the midwife. Women in this study were on high alert, assessing the behaviour of the midwife and identifying her behaviour as compassionate, or not. Anxiety related to perceived danger is common in pregnancy and in the early postnatal period (Bayrampour et al 2016). During this time women are hyper-alert to threat and danger and this may be a normal protective function. One explanation for this is the hormone oxytocin, which has an
important role in birth and breastfeeding. Oxytocin is associated with pro-social and nurturing and caring in all mammalian (including human) species, but it also has a role in threat detection and protection (Lischke et al 2012). All mammalian new mothers are primed to protect their young against perceived dangers. Therefore high sensitivity to others’ identity and behaviour are arguably part of a natural role. This sensitivity primes mothers to assess and identify strangers as friend or foe in an effort to protect the safety of their young (Gilbert 2015, De Dreu et al 2011). Further, the immediate awareness and sensitivity of women in this study to the midwife’s behaviour appears consistent with this biological threat response. Moreover this theory can also assist midwives and all birth workers to increase their understanding of the need to be sensitive to women’s emotions and behaviours around childbirth.

The significance of the woman’s experience of her midwife really being with her was striking in some of the interviews. At times when women were upset and emotionally distressed it seemed to act as compassionate ‘first aid’, as in the examples from Mary and Katrin in Section 6.4.3. It was on such occasions that the midwife’s presence appeared to have a therapeutic role. It was experienced as the midwife not only being with the woman but staying with her in that distress, holding a safe space for her to be upset and to be seen and listened to or psychologically held or contained. The concept of midwives holding space for women during birth was explored by Lemay and Hastie (2018) who called it ‘conscious presence’. Andrews (2017) contends that this is the ancient art of being with woman at birth. However, in this study, women appeared to experience midwives holding space as a compassionate and therapeutic response to their suffering during birth and also at other times in their pregnancy and postnatal period.

The findings of this study highlight women’s need for midwives who have the ability to stay with them when they are upset, distressed or in pain. However, staying with women when they are suffering can be difficult as it may trigger painful emotions for the midwife. As a result, midwives may use other tactics which divert the woman from her painful emotions. These may include diversion to another subject, focusing on physical pain or symptoms or dismissing their emotions. Dismissal may involve just failing to acknowledge the woman’s feelings, retreating or disengaging from the woman. Alternatively, midwives may fill the space, rather than hold the space (Andrews 2017) with talk or with administrative or technical tasks in which the focus is the computer, paperwork or the monitoring machines. In these situations midwives may be
‘absently present’ (Berg et al 1996). Similarly, Hunter (2002) described a ‘professionally detached stance’ adopted by midwives who felt unable to cope, which is unlikely to meet women’s needs. Staying with women who are suffering requires skills but also courage and this is why compassion and courage are linked (Koskinen and Lindström 2015) and explains why courage earns a place as one of the six C’s of compassion (Cummings and Bennet 2012). Additionally, it requires skills. Many midwives and other HCP feel inadequately prepared for the interpersonal and emotional aspects of practice (Henderson 2001, Smith (2009:xii). However, if compassionate midwifery involves not just noticing and recognising suffering but being confident to stay with suffering, then midwives need to develop the necessary qualities and skills for this.

In the past many pre-registration midwifery programmes have not taught counselling skills or advanced communication skills despite recognition that these skills are needed (Gibbon 2010) and it remains variable. Interestingly, within medical education, role play with the aid of actors, real or simulated patients followed by comprehensive feedback is now well established as the most effective method of teaching communication skills (Bell et al 2014, Berkhoff et al 2011, Kron et al 2017). It appears that midwifery may be ‘lagging’ behind in this respect. Midwifery students in the UK spend fifty percent of their course in clinical practice. This means that opportunities to practise skills and learn through observation of others is dependent on the skills of their mentors in the practice area. Consequently, this ‘watch and learn’ approach can lead to poor communication skills being perpetuated. Current educational standards for midwives in the UK include an essential skills cluster related to communication which includes listening skills and use of touch (NMC 2009). However, these do not go far enough in preparing midwives in the behaviours and approaches described by women in this study. A consultation on new educational standards for midwives which should come into force in 2020 (NMC 2018) should consider the findings of this study as a guide to educational standards for compassionate care.

Although it is widely recognised that midwives support women in distress on a daily basis, few receive any formal support with this part of their work. Lack of regular clinical supervision and the loss of statutory midwifery supervision in the UK, may contribute to this problem (Pollock et al 2017). It is encouraging that a new role of professional midwifery advocate is being developed and rolled out in the UK. A key competency in this role is ‘….developing new a leadership culture that will lead to quality, compassionate care for women and their families’ (NHS England 2017). However, little
is known about how this will be achieved as this is currently at an early stage of implementation. A new model of restorative supervision for midwives, called A EQUIP, may go some way to providing a new kind of support with the emotional stressors of midwifery work (Dabrowski 2017; NHS England 2017). This study suggests that midwives may need learning opportunities and support from educationalists and practice leaders to develop their ability to stay with women in their suffering and provide calm attentive presence and listening.

In terms of communication, simple, clear introductions emerged as compassionate communication in the early stages of being with the midwife or after handover. Lisa’s example of her midwives using the hello-my-name-is approach is noteworthy. This approach started through a Twitter campaign which highlighted the importance of all HCPs introducing themselves before they do anything else (Smith and Granger 2016). It is significant because it adds weight to national campaigns which can change and improve aspects of care in this way3. Additionally, Faith’s description of her midwife using simple introductions and establishing clear intentions to allay her fears, is another example of this. Her midwife’s words: ‘I’m [Name] and I’m gonna look after you’ demonstrate how this fundamental exchange of basic information is experienced as a compassionate response to an anxious and vulnerable woman in labour. When women experienced compassion through the midwife’s introduction it seemed to both inform women and reduce their anxiety. Introductions also appeared to represent an initial relational connection and a statement of intention to care, as in ‘I’m gonna look after you’. In this way introductions described in this study appeared to set the scene for the ongoing care and the development of a relationship with the midwife.

In this study a calm and relaxed approach was highly valued in terms of a compassionate response and this has been noted in other studies of women’s satisfaction with midwifery care and particularly within work on the birth environment (Huber and Sandall 2009, Westbury 2015). Because this study links a calm and relaxed midwifery approach to compassion it may provide clues as to why women want

3 The #hellomynameis campaign was started in 2013 by the late Dr Kate Granger MBE and has been spread primarily through Twitter. Dr Granger had terminal cancer and was frustrated by failure of staff to introduce themselves when she was in hospital as a patient. The campaign asked HNS staff to commit to introducing themselves to every patient. One of the NHS Trusts in this study ran a local #hellomynameis campaign during the period in which this study took place.
this type of midwife. More important than what midwives said or did, it was their approach that was particularly appreciated in the first instance. Frequently it was their lack of talking and their listening that was seen as compassionate:

‘…..(she) sat me down and just let me cry ‘ (Mary)

‘…..she was just sitting there quietly in the corner…..’ (Matilda)

‘…..quietly respecting the quiet when I wanted but physically being there…..’ (Mary)

‘…..it was like finally someone that I can you know talk to and they can just listen…..’ (Katrin)

Their ability to just be with the woman and not only notice her vulnerability, anxiety, and pain (suffering), but to stay calmly and quietly with her was key. Arguably this is in contrast to the reality of maternity care in the UK which may not always be consistent with this type of care. For example, the standard booking appointment between midwife and woman at approximately ten weeks gestation is usually a time limited, packed and prescriptive appointment in which the agenda is largely pre-set by the organisation (Phillips and Thomas 2015, Robinson 2005). However, for numerous reasons, early pregnancy may be a difficult time for a proportion of women. Women may come to a booking appointment feeling anxious or upset. Current systems of care would seem to restrict the time or opportunity for midwives to demonstrate compassion (as described in this study) in these circumstances, should it be needed. Increasingly women are not satisfied with care that does not provide the time and opportunity to have significant dialogue with their midwives from their first contact (NHS England 2016). It raises the question: How do midwives stay calm and attentive in very busy, pressured working environments? Women in this study identified midwives who appeared to do that. Importantly, their insights may provide clues about how midwives balance the needs of individual women with the needs of the system. Section 7.6 explores this further.

Touch also emerged as a compassionate response from midwives and while this has been explored in the midwifery literature it is often related to comfort measures and pain relief (Simkin and O’Hara 2002). For women in this study touch was seen as a compassionate response. However, it was less related to comfort and pain relief measures (like back massage) and more related to expressions of caring and connection. Some of the very specific descriptions of touch offered by women in this study may be useful for teaching midwives therapeutic touch. Student midwives need
opportunities to consider the use of touch and be able to practise and develop their non-verbal communication skills alongside other communication skills in safe learning environments.

7.4.2 Compassionate Midwifery though Relationships

This study provided a unique window into the nature of women’s compassionate relationships with midwives. This theme differs from the theme ‘Being with Me’ in which women described midwives ways of being that were calm, attentive and sensitive and noticed very quickly or even instantly by women. The theme Relationship was significantly different in that it represents how the woman and the midwife related to each other. As highlighted in the findings in Chapter Six, compassionate midwifery through Relationship involved women and midwives building reciprocal relationships by getting to know about each other as people. The two themes may be highly connected but they are different. One way they may be connected is that women who experienced midwives showing compassion through being with seem likely to have felt more trust towards those midwives. Therefore, they may have felt safe to reveal something of themselves and more inclined to be interested in the midwives as people and develop a relationship. Women and midwives got to know each other by exchanging information about their lives, a process which appeared to foster understanding and empathy. For example, Mary spoke of her midwife giving ‘a nice bit of self-disclosure’ (Section 6.5.3 of this thesis). Moreover, when this happened, continuity of the midwife facilitated compassionate care through an established relationship. Established relationships appeared to enable midwives to personalise care because they knew more about the woman, her life and her needs. There were clear accounts of this from the women in this study, for example, from Jessica in Section 6.5.1. Jessica attributed the compassion from her community midwife to the close relationship that she had with her, a relationship that had developed over her three pregnancies. However, paradoxically, midwife continuity did not enhance compassion for all of the women in this study. Beryl’s words in Section 6.5.1 described a lack of compassion from her community midwife and in her case midwife continuity compounded this as her unmet need for compassion continued to be unmet within a relationship that she experienced as distant. Moreover, this study revealed examples of woman-midwife relationships building very quickly in the absence of continuity models of care, sometimes over just one isolated episode of care.
These findings resonate with Hunter’s work on reciprocity in the woman-midwife relationship in which balanced exchanges were associated with emotionally rewarding relationships between women and midwives (Hunter, B. 2006). Moreover, these findings explored how reciprocal relationships are important to the way that compassionate midwifery is experienced. Hunter, B.’s (2006) study was with midwives who worked in the community and worked in ways that provided a degree of continuity of midwife. Similarly, in this study, some women experienced compassionate relationships with their community midwives. Continuity models (which ensure care is provided by the same midwife or small group of midwives) support relationship-based care and are associated with a number of positive outcomes in the literature (Forster et al 2016; Sandall et al 2015). However, there is little in the literature regarding the problem that continuity may create when there are woman-midwife relationships which don’t develop effectively as in Beryl’s case. This study suggests that it is the nature of the relationship that is key to compassion, over-and-above the continuity of midwife. Therefore, it is the dynamics of the relationship that count and as with any relationship. For a number of reasons, including personal compatibility and situational issues, relationships do not always work.

Notably, although some women in this study had a degree of continuity from community midwives, none had care from the same midwife, or small group of midwives, throughout pregnancy, birth and the postnatal period. Yet they all had experiences of compassionate care. In this study women made sense of their experiences of compassion from midwives by attributing this to the individual midwives involved and the meaningful relationships they had with them, however fleeting. There is little doubt that continuity of care should, and in this study appeared to, support and enhance the development of women-midwife compassionate relationships, but they cannot guarantee it. But this study concurs with the work of Dahlberg (2013) who found that it was both content and continuity that were important to woman-midwife relationships. Importantly, this study is a reminder that alongside the widespread call for continuity models in maternity care (NHS England 2016) there is also a need to acknowledge and plan for situations in which women-midwife relationships do not meet women’s need for compassion. Whilst this study is small in numbers, it points to the need for uncomplicated, guilt-free mechanisms which allow women to change midwife if they wish to.
7.4.3 Love

This study also highlights the intimacy and closeness of women’s relationships with their compassionate midwives. Women experienced compassion from midwives when they felt emotionally connected to them. May’s words in Section 6.5: ‘...you feel so close to them in that time....’ were part of her reflection on compassionate care from a midwife she had felt emotionally connected to while on the high-dependency unit. The emotional content of midwifery has been highlighted in the literature (Hunter, B. 2005). However, this stops short of exploring what emotion is actually involved here and what fosters its growth in midwifery. Gaskin (2002:271) talks of compassion and love as being the tools of midwifery. Hall’s (2012) work has shown that midwives find meaning in giving empathic and loving care. This would seem to go beyond a simple professional relationship. Yet Gaskin (2002) and Hall (2012) appear to be in a tiny minority when they talk of the loving side of midwifery. Love is a word that has many different manifestations, yet it is a word with which the midwifery profession seems uncomfortable. One reason for this relates to the culture of maternity care and its relationship with obstetrics. The legacy of the medicalisation of childbirth which is based on a realist approach which prioritises objectivity, measurement and control (Oakley 1980). This medical model of childbirth is at odds with an emotional approach which may be trivialised or ignored in obstetric models of care. Arguably, love as an important aspect of care has not been seriously explored because it is risky within this philosophical environment, although it is tentatively discussed in the literature on spiritual midwifery (Hall 2012; Gaskin 2002:271). Consequently, there has been little scope for developing a serious analysis on love in midwifery care. Nevertheless, Odent’s (2001) radical work on love and birth presents love as a necessary component of physiological birth. Although criticised for his radical approach to natural birth, much of what Odent claimed has since been widely supported in the literature on the hormonal and environmental factors related to physiological birth (Dixon, Skinner and Foureur 2013b, Geisel 2006, Hammond et al 2013, Stenglin and Foureur 2013). This study suggests that very close, caring connections between women and midwives, which appeared to be loving, were part of the experience of compassionate midwifery during birth and at other times.

A novel finding in this study is the way women linked compassion from midwives to a feeling of kinship and friendship. Women made sense of their compassionate midwife actually caring about them by identifying them as family or friends rather than professionals. There were many examples of this in women’s stories, including Jess
who talked of her relationship with her midwife as ‘like having a friend there that I’d never met before’, and Jane who likened it to ‘a sisterhood’ while May talked of compassion given in a ‘motherly way’. This resonates with the idea of the midwife as a professional friend (Pairman 2000, Walsh 1999). In the professional friend relationship, the midwife develops authentic, therapeutic relationships with women while remaining professionally accountable and responsible. This type of relationship has been associated with continuity models of care as in independent practice and small case-holding teams. This was very different to how care was organised for the women in this study, therefore how professional friend relationships work in larger maternity facilities, where there is very limited continuity, warrants further examination. Arguably, compassion may play an important role by harnessing some of the features of a close and caring relationship.

The midwife as a mother figure is a new and little documented perspective which emerged from this study. It is possible that women made sense of their close and intimate caring relationships with midwives by likening it to what is for most people their primary caring relationship; their mother. The mothering they described did not appear to make them feel dominated or disempowered; it appeared to comfort and nurture them. While mothering may have the potential for dominating women or infantilising them, this was not seen in women’s stories. It appeared to resemble genuine caring.

However, if within the woman/midwife relationship there is genuine caring which resembles friendship or kinship, it is also moderated by the cultural and legal dictates of the profession. The problem here is that while midwives’ professional standards dictate that care must be provided with compassion (NMC 2015) these also dictate professional parameters and boundaries which, as yet, do not recognise this kinship element of compassion. Clearly there are important issues here to be clarified concerning compassionate relationships between women and midwives. Currently, little is known about how midwives in the NHS manage these issues although there are accounts from independent midwifery practice (Garratt 2014). The examples from women in this study, who experienced compassionate midwives as being like their friends or relatives, therefore provides a resource for exploring this from the woman’s perspective. However, going forward, studies are needed on the experiences of midwives who successfully embrace the professional friend role, to increase and refine understanding in this area. McKellar et al (2014) draw attention to the real challenges reconciling relationship-based care and professional boundaries. In particular,
difficulties for women and midwives around leaving or ending these relationships have been noted (Leap 2000:9, Mills et al 2012, Rawnson 2011). Notably, in this study there was no evidence of dependent relationships beyond the episode of care. There was an enduring fondness and gratitude and expressions of feeling positive and enabled by compassionate midwives on their discharge from care: ‘the confidence was given to me about breastfeeding…..I went home on cloud nine’ (Jess). Nevertheless, this study was not designed to detect problems around ending relationships with midwives and severing close, compassionate relationships of any sort is potentially problematic. Moreover, in a world where keeping in touch through social networking has become the norm, it also presents challenges to personal privacy. Midwives and their professional bodies should consider all the implications of professional friendships as they draw to an end….or endure.

Likening compassionate midwives to close, female relatives is a particularly interesting finding because it further supports the evolutionary-psychology perspective on compassion as pro-social mammalian nurturing behaviour. It is what mothers do to protect and nurture their young and therefore it may be recognised as mothering behaviour by those receiving it. Again Odent’s (2009) controversial declaration that labouring women need the calm, quiet attendance of a mother-figure comes to mind. However, although Odent (2009) is against men in the birthing room, mothering behaviour is not always carried out by females. This study provides an example of mothering as a trait which crossed gender roles, given that not all the midwives described in this study were female.

There is some recognition by women and midwives in the value of mothering-the-mother, a term which encompasses one-to-one social and emotional support for a woman during birthing (Lynch 2010). Moreover, it is a caring, mother-like role, thought to improve satisfaction with care during birth and support breastfeeding in the postnatal period (Raphael 2012). Yet most maternity care settings in the UK fail to make this type of care a priority. To ‘fill the void’ some women engage a doula (Lynch 2010), an experienced lay person, to provide social and emotional support during labour and afterwards, leaving just the clinical care to midwives. Stevens et al’s (2011) study showed how midwives resented this splitting of their role and how they felt that doulas, were taking away this part of their job. However, women have a real need for this sort of support and some are willing to pay for a private doula to ensure they get it. Not all women can afford this add-on care and this creates the potential for a two-tier system.
of maternity care although there have been a few small scale schemes offering volunteer doulas to vulnerable women (Darwin et al 2017, McLeish et al 2016). This may be the one way forward as overstretched maternity systems fail to provide one-to-one midwifery for all women in labour (Campbell 2018). A survey in England by The Care Quality Commission (2018) found that approximately one in four women felt worried by being left alone during labour. However, women participants in this study, who discussed their compassionate care in labour, did appear to have one-to-one care, and this was likely to have contributed to their experiences of compassion, although it is clearly not every woman’s experience. Therefore the trend for using doulas is likely to continue unless midwives can find ways of prioritising this fundamental aspect of midwifery. Within the midwifery profession there is an important debate to be had on professional and ethical integrity of a theoretical split between clinical midwifery care, which only qualified midwives can do, and emotional care, which others can do. Crucially, this implies that clinical midwifery care could be delivered without compassion! Some women in this study reflected on midwives who had done just this:

‘I had one who was very clinical…. I didn’t want her to come back, I did it myself…..she was knowledgeable, professional etc. but she wasn’t particularly compassionate’. (Jane)

Jane’s words are an example of how this study contributes to the clinical-emotional care debate, by shining the spotlight on the high value that women in this study placed on compassionate relationships with midwives in which they received compassion alongside, and integral to, clinical care.

7.5 Compassionate Midwifery by Empowering

This study has uncovered women’s experience of empowerment as compassionate care. This novel finding does not appear to have been found in studies on compassion in the nursing or other areas of healthcare. Whilst this concurs with literature that links empowerment to high quality midwifery care (Haldorsdottir and Kelsdottir 1996, Walsh and Devane 2012), it is a new and exciting finding in terms of compassionate midwifery. It is important as it addresses this study’s research aim to explore women’s lived-experience of compassion and the sense-making around it. Additionally, it contributes to a much needed understanding on the nature of empowerment in midwifery care (Hermansson and Mårtensson 2011), by showing how women’s experiences in this study linked it to compassionate care. Women’s stories included
many examples of how, when midwives provided them with information, teaching and coaching, in the right manner (on their level) they felt more empowered. The three emergent themes: giving information, teaching and coaching and on my level will now be critically examined in turn.

Women in this study gave a clear message: compassionate midwifery is experienced when knowledgeable, willing and able midwives provided them with pertinent information, because not understanding their care and not knowing what was happening made them feel anxious. Providing them with the information they needed appeared to address this anxiety and reduce it and as such it was identified as compassionate care. Jess’s words in Section 6.6.1 seem to sum this up:

‘I think the big thing was putting you in the know..... if you don’t have the knowledge, you don’t know what you’re dealing with, you don’t understand the situation and then that’s when things spiral out of control’.

Jess’s words above link back to the need for compassionate midwives to be both emotionally and clinically competent and knowledgeable, discussed previously in Section 7.4.2.

Compassionate midwifery as represented by the sub-theme Giving Information was an unexpected finding as, again, it is not an obvious feature of compassion in the wider literature, however it does make sense as a response to feelings of anxiety, uncertainty and lack of control. These feelings were common to all aspects of the childbirth journey for women in this study, but the transition to motherhood, even for women having their second or subsequent babies, seemed to be a time when women had particular information needs. Postnatal anxiety is common, yet often goes unrecognised (Goodman, Watson and Stubbs 2016). Feelings of anxiety related to the transition to motherhood were distressing for some women in this study, who experienced a lack of confidence in their abilities. Such feelings, depicted in Beryl’s words: ‘I think your confidence goes, you don’t know what you’re doing’ are reflected in the literature on women’s postnatal experience. Coates, Ayers and de Visser (2014) explored women’s experience of postnatal distress and anxiety. Participants in their study described an emotionally demanding period of adjustment: ‘the shock of the new’. They identified the need for interventions which support women with postnatal emotional difficulties although they did not recommend any. However, many studies have highlighted women’s informational and support needs during the postnatal period (Beake et al
2010; Dykes 2005; Khan and McIntyre 2016) and information has the potential to reduce anxiety (Chudleigh 2017). Not the routine list of standard information when midwives on the postnatal ward had to ‘say certain things’ (Imogen) nor the doling out of leaflets when a midwife ‘forced leaflets on me’ (Mary). What was notable about the women in this study of compassion from midwives, was that when midwives met their particular information needs their distress and anxiety was reduced and therefore they considered this to be compassionate care. This finding not only highlights the importance of the way that information is given, it indicates that providing women with the personalised (rather than standardised) information may be both a compassionate and an effective intervention for postnatal anxiety.

This study also found that women welcomed information which explained their care or presented their options. They also wanted to be shown how to do something, if they didn’t know how to. They experienced these interactions as compassionate care because it made them feel less anxious and more empowered in their role as new mothers. Consequently women recognised compassion as something that went beyond emotional care; compassionate midwives needed to be knowledgeable and skilful as well. As Mary explained, the compassionate midwife that she remembered, who gave her information and options: ‘seemed more knowledgeable’ and ‘bit more on the ball and a bit less fluffy’. This study indicates that midwives need to be knowledgeable and possess sound teaching and coaching skills in order to provide compassionate midwifery to women. This appeared to be particularly important to keep women well informed, facilitate choices and help them to develop their capabilities and confidence. Women believed that midwives could not be compassionate if they were not also knowledgeable and competent. Whilst there is an established argument that compassion should not be an optional addition to knowledge and competence (Haslam 2014), findings from this study turn this on its head by indicating that knowledge and competence are not optional when it comes to compassionate midwifery.

However, the concept of compassion, competence and knowledge going hand-in-hand is represented in the wider literature in healthcare and it has been particularly noted to be a key to person-centred care and supporting the person to increase their capabilities (Entwistle and Watt 2013, Sharp, McAllister and Broadbent 2016,). Somewhat confusingly, several concepts combining compassion with intelligence exist: intelligent kindness, compassionate competence and emotional intelligence are all worthy of some critical debate in relation to the findings of this study. Firstly, intelligent kindness
as described by Ballat and Campling (2011) brings together kindness (or co-operative human connection) with sophisticated thinking about the conditions in which this thrives. This broad concept, although very relevant to maternity care (Campling 2015) does not capture women’s experience of the role of midwives’ knowledge and skills in compassionate midwifery within this study. However, it can assist in understanding the links between kinship and compassionate midwifery discussed in Section 7.4.3.

Secondly, *compassionate competence* as described by Esposito (1999) and Stevens (1996) relates to women’s need for practitioners who are competent; although that competency alone is insufficient because they require care which meets both their clinical, emotional and informational needs. This does appear to be similar to what women in this study experienced although they experienced knowledge and competence as part of compassion and less as a blend of two qualities. Thirdly, *emotional intelligence* in midwifery refers to a midwife’s ability to ‘recognise her own feelings and those of others’ (Patterson and Begley 2011) and arguably this appeared to be evident in the midwives that featured in women’s stories within this study. Specifically, they described midwives ability to tune-in, build caring relationships and understand them. Such skills would appear to require emotional intelligence. However, emotional intelligence on its own does not imply intellectual knowledge or clinical competence (Goleman 2004) although it complements these (Patterson and Begley 2011). Furthermore, women in this study found that the midwife’s knowledge and competence was essential to meet their information needs and develop their sense of agency and self-confidence. Therefore while emotional intelligence is important and supports compassionate midwifery the concept of *compassionate competence* appears closer to what women in this study meant when they experienced compassion that made them feel more empowered. Therefore this concept may be ripe for further exploration in terms of midwifery as it could provide a model for integrating clinical and emotional care in midwifery education.

It was not just what midwives said and did that empowered the women in this study, crucially it was how they did it. Women in this study wanted midwives to inform, teach and coach them and they perceived this to be compassionate midwifery when midwives used a non-hierarchical approach. This approach was encapsulated in the phrase: ‘on my level’. This novel finding is important because it highlights women’s sensitivity to the power relationships within maternity care and how they might constrain women’s empowerment. Compassion as informing, teaching and coaching were responses to women’s feelings of anxiety and disempowerment at a time of great
change. Women’s narratives described feelings of anxiety related to not knowing enough and lacking confidence. In the post-natal period they worried that they would not know how to look after their baby or that what they did would not be good enough. Beryl’s description of herself as ‘clueless’ was not unusual and was an example of women’s keen sense of their lack of skills and knowledge. Moreover, women appeared to worry that they would look stupid in front of others, including professionals, and that they would be found lacking. The way that knowledge can be used as power is key to understanding the significance of this finding.

Foucauldian and feminist theories of power offer ways to understand how women in this study experienced compassion from midwives when they provided information and offered teaching and coaching. Foucault (1926-1984) argued that control over another is demonstrated through a system in which knowledge equals power (Worman-Ross and Mix 2013). Medical knowledge on reproduction sees bodies as ‘other’, and potentially faulty (de Beauvoir 1949). Reproduction is therefore seen as pathological (Cahill 2001) and specialised authoritative knowledge serves to control the hazardous process of childbirth. Historically, midwives and other healthcare professionals working in Western healthcare systems have aligned themselves with the dominant (medical) culture and not with woman. The professionalisation of midwifery in the UK based on the Midwives Act of 1902, achieved medical control over a well-trained workforce (Kirkham 1999). Despite legal and strategic changes over the last century, this legacy of medicalised control continues to undervalue women’s position in today’s maternity services, leaving them disempowered. Although maternity care is thought to be gradually moving away from this culture, midwives have been slow to challenge medical dominance on womens’ behalf in maternity settings. Organisations that represent women, like the National Childbirth Trust (NCT), have been influential drivers of change (Johanson, Newburn and MacFarlane 2002). Furthermore, the growth of business models of healthcare may simply be replacing one type of power and authority with another (Crawford et al 2014). Power over women and midwives is important here because the evidence from around the world is that disempowered midwives provide poor care. When midwives are empowered they are better positioned to empower women (Bohren et al 2015; Page 2014, Shimoda et al 2018).

The compassionate midwives described in this study appeared to offer women knowledge and skills without an authoritative stance. Arguably, it was not just the new
information or skill that helped women feel empowered, the midwife’s approach was a large part of it and in combination it was experienced as compassionate care.

What was most striking in this study was the way that women did not talk about compassionate midwives being professional, they talked about them as being ordinary, human, normal. While they valued their experience and knowledge, they saw the compassionate midwives as the ones who imparted their knowledge within an equal relationship. It was imparted as one human being to another. It could be described as an expression of shared humanity. The compassionate midwife did not see women as ‘other’ and neither did women see the midwives as ‘other’, because in compassionate exchanges there was no power relationship.

Furthermore, midwives who used their human self rather than their professional self and treated women as equals, quickly reduced women’s suffering and made them feel more empowered. Interestingly, this resonates with the literature on managing emotions at work and in particular Hochschild’s (1983) seminal study which explored emotion work of airline staff, previously discussed in Section 3.5.4. Hochschild’s (1983) comparison of presenting the professional face, which involves ‘surface acting’ and the ‘authentic face’ may be one way of interpreting this finding. Arguably, when the compassionate midwives in this study provided information, teaching and coaching to women they used their human face. However, rather than this being the ‘deep acting’ described by Hochschild (1983), in this study it appeared (to the women) to connect the woman and midwife on a deeper and more authentic level. Paradoxically, this human face seemed to be especially relevant when they were imparting their professional knowledge. At these times compassion seemed to be dependent on midwives relating to them in an authentic, person-to-person manner rather than a person-to-professional manner. Furthermore, the fact that so many women felt that their midwife actually, really or genuinely cared about them suggests that these midwives were not acting, they were genuinely connecting on an emotional level.

This study, therefore challenges issues around professionalism in midwifery. It raises questions about whether professionalism is always in the best interests of the woman. The obligations and responsibilities of being a professional may impose professional boundaries and a feeling of separation or ‘otherness’. When Jess said: *I didn’t get a sense of the uniform if you like…..’* it was not an observation about clothing. She was describing the absence of a professional boundary which indicated identity and status
(Timmons and East 2011). Many midwives and other HCP enjoy their professional identity and status. However, this may create power imbalances and be at odds with a compassionate, humanised approach to women receiving maternity care.

7.6 Balancing in Compassionate Midwifery

The balancing work of midwives as part of women’s experience of compassionate care was widespread in this study and these experiences represent some of the most unexpected findings. Three emergent themes were identified which represented three different areas of care in which women described the midwife’s ability to show compassion through their ability to balance paradoxes, contradictory perspectives or conflicting demands. These were conceptualised as the Familiar and the Unfamiliar, the Mother and Baby and the System and the Individual.

7.6.1 The Familiar and the Unfamiliar
Women in this study discussed childbirth as being something extraordinary and amazing in their life and yet they had an awareness of how it was very familiar to midwives. Women noticed how their compassionate midwives were able to appreciate this and embrace both the familiar and the unfamiliar nature of birth. It appeared important that compassionate midwives were seen as being able to see it as ‘all in a day’s work’ (Louise) and yet at the same time that ‘it’s a really big deal to somebody’ (Imogen). It is true that most people who witness an individual birth see it as something of a miracle and yet it is a fundamental and very frequent event for the human race. It happens all the time, yet it happens very infrequently (if at all) to individual women and is therefore extraordinary to them. It is both a universal part of life and highly personal and life-changing. Consequently, it can be seen as both routine and remarkable. This paradox is what Staehler (2016) refers to as the ‘uncanniness’ of birth. Staehler contends that, in this way, birth has some similarities to death. Just as nobody can know what it will be like to die, for an individual woman, the uncanniness of birth can be keenly felt. As she approaches birth and motherhood she may understand the reproductive process, but she can never really know what it will be like for her and how birth and motherhood will change her as a person. It is therefore unknowable and unimaginable (Kemp and Sandall 2010). This mystery surrounding birth may be experienced as a spiritual quality or awareness by some women and also by some midwives (Hall and Crowther 2018:13). In this study there was a sense of midwives being seen as both down-to-earth and other-worldly ‘like angels’ (Louise). Although
spirituality in relation to birth has been explored in the literature (Linhares 2012, Moloney and Gair 2015, Pembroke and Pembroke 2008), this study provides a rare example of how women may experience midwifery as spiritual. Therefore, balancing may represent a tangible link between compassion and spiritual midwifery.

Arguably the most surprising finding in this study was that tea was identified as a symbol of compassion from midwives. Making and offering tea appeared to be one way that women experienced midwives balancing the routine and the remarkable. However, this finding can be considered on a number of levels. Tea is also known for its effects on the mind and body (Einöther and Martens 2013, Pan et al 2017). Yet this does not explain its important role in this study. One explanation is that tea was an extension of the caring friendship or kinship roles that women experienced as part of compassion from midwives. Tea, refreshments and other non-clinical home comforts where seen as a part of that close, intimate, caring activity that resembled something a close friend or family member might do for them. In this way it seems closely linked to compassionate relationships discussed in Section 7.4.2. Faith’s midwife said she would go and get her tea and toast and run a bath for her. She remembered:

‘I almost just burst out crying! Cos I just thought you’re just so kind and you’re really looking after us here’.

These small acts of ‘looking after’ may represent important rituals that reinforce kinship bonds, thus increasing women’s feelings of safety and contentment. They seemed particularly important to women immediately after birth and appeared to have a calming or grounding effect at this time.

A theoretical framework which may help to illuminate this finding is Sense of Coherence (SOC) theory. Arguably, it provides some possible reasons why tea and other home comforts were highly connected to compassionate midwifery. SOC is part of salutogenic theory developed by Antinovksy (1979-1994) (Vinje, Langeland and Bull 2017) which focuses on the physiological, psychological, sociological, cultural, and spiritual factors that combine to create and maintain health in individuals. Sinclair and Stockdale (2011) argue that this is a highly appropriate model for midwifery care as its focus is on health giving factors. They argue that this is more suitable than a medical model of care with its focus on disease and risk factors. In salutogenesis, SOC represents an individual’s ability to see life’s activities as comprehensible, meaningful, and manageable, and the protective effect this has on their health (Eriksson
Lindström 2005). A strong SOC is associated with a number of healthy outcomes in the general population (Eriksson and Lindström 2005) and with increased emotional health for childbearing women, including less depression, anxiety, stress, worry, and PTSD (Ferguson, Davis and Browne 2013, Perez-Botella et al 2015). The unfamiliar nature of birth (its unknowability or uncanniness) threatens women’s SOC and yet women need to find a SOC in order to embrace the birth experience and the transition to motherhood and move on with their lives (Kemp and Sandall 2010). The findings of this study suggest compassion from midwives was experienced when midwives used familiarity (including tea and home-like comforts, familiar environments, kin-like relationships and carefully-judged humour) to balance the familiar with the unfamiliar. This seemed to start to embed the unfamiliar birth experience into the familiarity of normal life, thus building a SOC.

The act of offering and making tea also has cultural significance. Clearly the well-known catch phrase ‘Keep calm and drink tea’ has become something of a cultural meme. However, the slogan is based on the 1939 UK Government motivational poster ‘Keep calm and carry on’, which evoked the quality of fortitude and the need to stay calm in adversity as the British public braced itself for air attack (Irving 2016). The poster has been imitated in numerous ways, nevertheless ‘Keep calm and drink tea’ captures the essence of the wartime original as it makes a tongue-in-cheek reference to the ‘Britishness’ of tea as an antidote to anything alarming. An awareness of this cultural concept illuminates the place of tea in this study. It was as if the tea that the midwife made and served to women bought a sense of calm to the remarkable (and often overwhelming) experience of childbirth. In the UK offering tea and toast after childbirth is common and some midwifery textbooks refer to it (Chapman 2013). However, while it has been reported anecdotally, there is no academic analysis or research on this practice in the literature. Perhaps making tea is seen as too frivolous or irrelevant for such attention? If so, this study challenges that position, inasmuch as it is the first to highlight women’s experience of tea-making as a symbol of compassionate midwifery care. The women participants were predominantly white British, and this finding may not have emerged in a more culturally diverse group. Whilst some aspects of compassionate care are universal, there are some elements that seem culturally specific (Papadopaulos et al 2016). Tea may be an example of this. The art of making and drinking tea is not common to all cultures and even for people in tea-drinking cultures, considerable differences in the type of tea and methods of making and serving exist (Fair and Barnitt 1999). The sorts of drinks, foods and
other gestures that act as symbols for compassion following birth are likely to be culture specific. Midwives who develop an understanding of these will be better placed to provide culturally compassionate care. Particularly after birth, many different food and drink practices exist within different cultures, which may be meaningful and comforting to women (Diamond-Smith et al 2016, Eberhard-Gran et al 2010). Midwives can develop cultural competency by developing a curiosity and openness towards different cultural norms and preferences rather than assuming that their own norms and preferences apply (Sederstrom 2013).

In addition to experiences immediately after birth, some women in this study, experienced tea as part of compassionate midwifery at other times. This was at times when they were upset or anxious during pregnancy or the postnatal period, for example when May was admitted to hospital with high blood pressure. Similarly, at these times tea seemed to calm and settle women with dramatic effect as in May’s examples in Section 6.7.1. May’s question: ‘are they taught how to make that tea?’ is important here. It suggests that it was not just ordinary tea. May’s words illustrate the powerful effect it seemed to have on her, which she could not fully understand herself. It was as if she was suggesting that the tea had extraordinary or special properties. Currently, tea-making is unlikely to be a part of pre-registration education programme, and some might argue that there is no need to teach such a simple, frivolous task. However, this may be a serious omission because this study indicates that tea making and serving has much to offer. Moreover, a full understanding of the part that tea and other symbols of compassion play in women’s care is needed. Tea is an inexpensive, much appreciated aspect of care that, in certain circumstance, women experienced as calming, comforting and compassionate.

Humour can be seen as another simple yet significant symbol of compassion. Again it appears to be closely related to the superordinate theme Relationship, but it was also a part of the balancing work by midwives described in this study. Humour can enhance feelings of closeness and trust within care relationships and it can also act as a coping mechanism in stressful situations (Tanay, Roberts and Ream 2013). Humour can work as an emotional regulation mechanism (Samson and Gross 2012) and it has been previously noted to have this function for some women during pregnancy and childbirth (Hunter 2002, Shirley 2015) which may explain this finding. Careful use of humour, informed by relationship building, in the right context appeared to offer women participants balance in difficult or emotionally charged situations. Humour, as a symbol
for compassion may be received with surprise and caution by some midwives, as it is not hard to imagine ill-judged attempts at humour going badly wrong. As comedians know, timing and tone is everything. It seems likely that a midwife’s ability to tune-in to the woman and develop a relationship with her are key to humour working well. For the women who experienced humour as compassion in this study, it seemed to provide a warmth and comfort to their interactions with midwives, even when the subject of that humour was suffering and pain, for example with Jessica following a stillbirth. This study indicates that humour can be part of compassionate care and methods aimed at developing compassion should pay attention to ways in which humour and a sense of playfulness can enhance care.

7.6.2 **Mother and Baby**

Women experienced compassion from midwives in the way they balanced care for themselves and their babies. During postnatal care women linked compassion to a continued focus on them rather than it being all about the baby. These findings are consistent with other studies which have reported on the beneficial effects of feeling listened to and cared for in the postnatal period by HCP who were there for them (Hadfield and Wittkowski 2017). Women in this study also wanted midwives to have an understanding of the mother/baby relationship. Particularly when there were concerns about the baby, recognition that the mother and baby’s wellbeing were mutually dependent was perceived as compassionate care.

Interestingly, national postnatal guidance in UK (NICE 2015b) states:

> ‘Acknowledge the woman’s role in caring for her baby and support her to do this in a non-judgmental and compassionate way’.

Although this guidance is consistent with the experiences and views of the women in this study, it emphasises the woman’s role rather than the physical and emotional symbiosis within the mother/baby dyad. Most of the postnatal women in this study had experienced some problems establishing breastfeeding and particularly the four women whose babies had significant weight loss appreciated being seen as connected with their baby. In addition to this, a midwife who focussed attention on the mother in order to overcome feeding problems was common to all four women’s experiences of compassionate care. Given that breastfeeding means that even after birth, the baby continues to be dependent on the mother’s body, this finding is consistent with theories about breastfeeding and early attachment. Kitzinger’s (1975) description of the ‘fourth
trimester’ reinforces this idea that for both mothers and babies the early postnatal period has a lot of physiological and psychological similarities to pregnancy because the mother is still sustaining, nourishing and ‘growing’ her baby. Although outside of her body, the baby remains dependant on her for all life-sustaining needs. This also connects to a better understanding of breastfeeding as part of a loving mother-baby relationship rather than simply a feeding option (Entwistle 2015). Postnatal care that is ‘all about the baby’ is rooted in a paternalistic, medical model of care which views the woman as a vessel for a baby and birth as separation or delivery from this state (Katz-Rothman 1991:275-9). Postnatal care practices reflect this, with patterns of appointments scheduled and largely dictated by aspects of monitoring the baby, for example weighing and screening tests. These are activities which have an important place but they are not a substitute for holistic midwifery care. The findings of this study indicate that midwives who balanced both the baby and the mother’s care by ‘looking after mum and baby as a team’ (Maree) provided care which women experienced as a compassionate response to their suffering and distress around this experience. Moreover, for the women in this study it appeared to be effective care. It may be that this ability to balance the mother and the baby’s needs and care also puts midwives in the best position to work with the mother to support the wellbeing of both, and by extension, the whole family. Women who had experienced postnatal feeding problems and whose babies had been identified by midwives as having significant weight loss, found these experiences very distressing and therefore had a need for compassionate midwives. This study has highlighted this experience from the mother’s perspective. Women had a keen sense that they were key to their baby’s health and wellbeing at this time and responded well to midwives who recognised this.

7.6.3 The individual and the System
The organisational constraints on midwives’ time were clearly evident to the women in this study. They had a high level of insight into the challenges that midwives face in modern NHS maternity systems. Women wanted personalised care but understood that midwives also have to look after other women and do the system’s work. Women saw that midwives had administration, documentation and computer work to do and they seemed to accept this. Most of the women were in professional and semi-professional occupations and there was a sense of them understanding the administration and bureaucracy that is a feature of modern healthcare. However, the findings suggest that these aspects of midwives’ work could affect midwives’ ability to demonstrate compassionate care. Importantly, when women talked about
uncompassionate care it was rarely about an unkind or insensitive midwife. More often they compared compassionate midwives with midwives who primarily focussed on the systems work and they referred to this as *mechanical, tick-box or production line* care. There was a surprising level of empathy and insight into the challenges that midwives face. Even in their experiences of midwives who provided mechanical or tick-box care, women showed some empathy for midwives working in a difficult system. This was somewhat surprising and yet it is consistent with theories around compassion as something that flows in all directions. Gilbert (2014) describes compassion as flowing in three directions self to other, other to self and self to self. Although self to self-compassion did not emerge in this study, there are accounts in which compassion appeared to be reciprocal, indicating that when women receive compassion from midwives, they are also inclined to be compassionate back. This suggests that compassionate midwifery may have potential benefits when trying to manage competing demands and heavy workloads, because women are more likely to empathise with their midwife’s position and have some compassion for them.

However, in this study, compassionate midwives were noted for their ability to be compassionate and apparently manage their workload. Uncompassionate midwives were noted for their focus on the system’s work. This finding is consistent with the observation that the bureaucratic, business model of health care which prioritises policies, standards, targets and statistical data, creates a barrier to compassionate care (Ballatt and Campling 2011, Dixon 2014). In this study, women contrasted compassionate midwifery care, with mechanical midwifery care. In this sort of care midwives were described as primarily focussed on record keeping and information was obtained through scripted or pre-set questions. Women want and need an open conversation with midwives rather than endless closed questions (Robinson 2005). These provide little opportunity for women to voice their concerns and in this study gave the impression that midwives were not interested. Consequently, women didn’t feel they would want to talk to them about their concerns even if the opportunity did arise.

Following a far-reaching consultation on maternity care in the UK, there is widespread acknowledgement that midwives spend far too much time on administrative tasks and there are calls for electronic maternity records to be rolled out across the UK to aid communication and data collection (NHS England 2016). However, suggestions that computerised record keeping will reduce workload has yet to be realised (Scantlebury
The stories in this study tell of women who had experience of the records or the computer work being the focus of midwife’s work. Unsurprisingly this made care seem more mechanical. Some of the women had reflected on this and wondered if there might be ways round it: ‘I don’t know if there’s another way it can be done that doesn’t feel like a tick-list?’ (Imogen). Others gave examples of midwives who they had witnessed balancing the work of the organisation and compassionate care by using different strategies, for example: ‘she did all the paperwork at the end’ (Mary). The burden of record keeping in maternity care is considerable and it is influenced by strong messages from professions and organisations that record keeping is an essential feature of midwifery with legal, data collection and communication functions (Kerkin, Lennox and Patterson 2017, NMC 2015). Meeting these requirements and providing individualised attentive care can be a challenge. What is novel in this study is that women identified the midwives who could balance these competing demands so that the woman still felt they were the focus of care.

There is already some evidence that a good midwife can compensate for organisational deficiencies (Nicholls and Webb 2006), however, in this study women identified midwives who did this as compassionate midwives. While MacLellan (2014) noted that some midwives are able to meet the challenges of balancing institutional demands with women’s needs, this study provided valuable snapshots of how midwives managed to work in this way. Women in this study clearly recognised and appreciated when midwives were able to balance the organisational demands of the job (or the system’s work) with personalised care for them. Individual cameos of midwives emerged in women’s stories which demonstrate attentive, authentic communication with woman in which they didn’t overtly use pre-set lists or tick-boxes but gained information within a conversation. As Mary remarked: ‘the focus was all on me, it wasn’t two sentences and onto the computer...’ The compassionate midwives appeared to complete records in an unobtrusive manner. There was a sense that these midwives had time for them first and foremost and they fitted record keeping around that. What is less clear is how these midwives managed to do this when others could not. This study suggests that finding out more about what enables them to do this may help to develop other midwives’ skills in balancing the work of the system with the care of individual women.
7.7 Compassion as an Intervention for Women’s Suffering

Women participants experienced compassion from midwives as a response to their suffering. Although they rarely used the actual word: suffering, when they told their stories of compassion from midwives, it was predominantly against a backdrop of suffering. Women talked openly about their vulnerabilities, anxieties, physical and emotional pain, problems and complications and the difficulties experienced as new mothers that caused them sadness and distress. As such, these were all synonyms for suffering (Morse 2001). Moreover, the apparently high level of suffering experienced by women in this study was unlikely to have been a matter of chance. The appreciative approach in this study, meant that the focus was on women who had received compassionate midwifery and as a result those women also had a need for compassion. Therefore, the fact that two women had experienced stillbirth and others had a history of PTSD, long-standing anxiety, tocophobia and a variety of obstetric and neonatal complications, was unlikely to be a coincidence. On the contrary, it was because they had come forward to talk about how their need for compassion (their suffering) had been responded to effectively by a midwife. This was reassuring in terms of answering the research question: What is the lived experience of compassionate midwifery? Women were, in essence, describing a midwife’s response to their suffering selves. Therefore, they were, by definition, describing compassionate midwifery, rather than just a midwife’s pleasing behaviour in isolation. As a result this study achieved its objectives of identifying women who believe they have personally experienced compassionate midwifery care and the ways in which women experienced it to gain an understanding of its impact. It is this focus on compassion that makes this study unique. Although other studies have explored the experience of the childbirth (Halldorsdottir and Karlsdottir 1996), midwifery support in labour (Berg et al 1996; Iliadou 2012), empathy and spiritual care (Moloney and Gair 2015) and the qualities of a good midwife (Byrom and Downe 2010), this study identifies and unpacks the experience of compassion and its impact.

The finding of this study represented by the theme: Women’s Need for Compassion, is key to understanding women participant’s experience of compassion, because this finding represents their suffering. The concept of suffering, discussed in Section 3.3.4 which was central to understanding compassion in its generic form, is now central to understanding compassionate midwifery. The word Compassion emerged in healthcare post-Francis, in response to the tragic consequences of a failing contemporary
healthcare system as discussed in Chapter 2 of this thesis. When Francis (2013a) talked about compassion it was radical because compassion had not been a strategic priority in healthcare before. Francis (2013a) highlighted the need to humanise healthcare and frame it in the context of caring about our fellow human beings. He had seen evidence of human suffering and wanted to see compassion in response to it.

One of the reasons that nursing embraced the call for compassionate care more than midwifery did, may be that while the concept of suffering is not new to nursing (Liu, Hsieh and Chin 2007), it did not resonate with the midwifery profession. Arguably in midwifery, drives for safety have been paramount although dignity and respect for human rights during childbirth are gaining recognition and organisations such as Birthrights (2018) and the White Ribbon Alliance (2013) pursue these goals on behalf of women in this country and internationally. Maternity services are becoming more aware of the need for respectful maternity care. However, although respect is vital in maternity care and in this study it sometimes formed part of a compassionate response, it is not, in itself, compassion. This is because compassion is a response to suffering, therefore compassionate midwifery must be a response (by midwives) to suffering. Moreover this is now corroborated by definitions, a concept analysis (Ménage et al 2017) and the findings of this study.

Nevertheless, there is a fundamental barrier to understanding compassionate midwifery, because suffering is an unacknowledged phenomenon in midwifery and not a concept that the midwifery profession is comfortable with, as highlighted in Section 3.3.4. In maternity care there is an acceptance of pain, anxiety, depression and PTSD and yet not suffering. To substitute suffering with a medical label may have had some benefits in terms of categorisation, measurement and treatment. However, such labels are limited. A diagnosis of PTSD for example will provide a way of organising and describing a person’s symptoms and it can guide treatment options but it does not further an understanding of a person’s experience of it (Isovaara, Arman and Rehnsfeldt 2006). Similarly, women in this study tended to use medical diagnoses or at least medically accepted terms as synonyms for suffering (Morse 2001). Alternatively they used descriptive non-medical language that indicated feelings of distress, as in: ‘….I was in absolute bits…..’ (Maree) or being in a ‘mess’ (May and Mary) or they reflected on their feelings of ‘struggling’ (Louise, Mary, Maree, Beryl, Imogen, Katrin). Suffering may not have been the word they used but it was in between the lines and evident from their accounts and sense-making of the care they received during their pregnancy and childbirth experiences. Nevertheless, suffering is an important word, not
only because it is key to understanding compassion. It also represents a far bigger concept than pain or anxiety. It is a much broader phenomenon, concerned with how an individual feels, thinks and behaves in relation to their pain, anxiety and other triggers and how it impinges on their life and their sense of self. Medical terms or symptoms, for example PTSD or even pain, represent an outsider perspective and objectify distress through illness labels (Lee 2066). Using medical labels for suffering and distress is something of a double-edged sword because although there are potential benefits, the implication is that it is abnormal and requires professional help. Medical labels place women in a victim role when their negative feelings may be part of a difficult, yet essentially normal, process of adaptation and growth (Lee 2006). Whatever the label, there is widespread agreement that women want support with their difficult and distressing emotions around childbirth, yet specialist, professional support may not be the panacea. On the contrary, one of the most novel and important aspects of this study was that it was often support from midwives who were like family or friends that reduced the women’s suffering and distress.

Arguably, acceptance and awareness of another’s experience of suffering is fundamental to personalised, holistic care. Women in this study revealed how suffering is highly personal and contextual. Their past experiences, expectations, values and norms, socioeconomic and cultural factors are all likely to have impacted on their experience of suffering around childbirth and transition to motherhood. Suffering was evident in women’s expressions of negative feelings about themselves and their situation, for example ‘I didn’t feel like myself’ (Katrin); ‘I felt a bit rubbish in myself’ (Faith); ‘It was a bit shit really’ (Mary); ‘I wasn’t doing a very good job’ (Helen). Crucially, the findings of this study indicate that when women share their experience of suffering to a compassionate midwife their suffering decreased. This is a powerful mechanism which is likely to depend on both a woman’s willingness to show her vulnerability and the midwife’s awareness of, and sensitivity to, suffering.

Anxiety was the most common issue discussed by women participants. Sometimes spoken of as ‘worry’ ‘terror’ or ‘fear’, the word anxiety is used here to encompass this group of related emotions. Arguably, many of the other issues women discussed, for example: problems and complications, breastfeeding problems and transition to motherhood also involved undercurrents of anxiety. Anxiety in pregnant and non-pregnant women is common (The Mental Health Foundation 2018) and this is a rising trend. Anxiety is now so common Reiger and Dempsey (2006) call it a normative frame
of reference within contemporary society. Younger women between 16-24 years old are at particularly high risk of a common mental health disorder (depression and anxiety), which affects one in five young women (McManus et al 2018). Additionally, it is estimated that around one in four young women have self-harmed (McManus et al 2018). This epidemic of mental health problems in young women is, and will continue, to impact on women as they become mothers and bring challenges to maternity services. Consequently, women’s anxiety in this study was not surprising and it is an issue which has been explored in the literature. A meta-analysis on the experience of antenatal distress (including anxiety) found that women experienced feelings similar to grief during pregnancy as they start their transition to motherhood and that these feelings are exacerbated by feelings of inadequacy in comparison to an ideal (Staneva, Bogossian and Wittkowski 2015).

In contrast, pregnant women in this study on compassionate midwifery, related their anxiety chiefly to medical complications and past experiences. There was a sense that pregnancy is an inherently stressful time: ‘….cos its nine months long and there’s a million things you can worry about…..’ (Jovey) and that extra risks and complications either with their current or past pregnancy takes this background anxiety to a new level. However, anxieties associated with their transition to motherhood and feelings of inadequacy also featured in women participant’s postnatal experiences. Anxiety in pregnancy is associated with a number of risks including increased risk of premature birth (Rose, Pana and Premji 2016), low birthweight for gestational age and pregnancy-induced hypertension. Effects on their children include increased anxiety, negative temperament, behavioral and developmental problems. Many of these adverse fetal and infant outcomes are thought to be related to fetal overexposure to maternal cortisol and serotonin, placental changes, and epigenetic changes triggered by increased maternal anxiety (Stein et al 2012). The very serious consequences of prolonged maternal anxiety mean that any interventions that can reduce the extent or the duration of that anxiety have the potential to improve outcomes. Women in this study experienced compassion from midwives as something that was able to reduce their feelings of anxiety and for them it was an effective intervention for anxiety.

Although research on postnatal depression is well established, recognition of postnatal anxiety as a significant cause of postnatal maternal distress is relatively new (Pallant, Miller and Negri 2006). High prevalence and incidence of anxiety in new mothers has been noted and associated with a number of poor outcomes for women and their
children (RCM 2012). However, the extent of the anxiety described in this study was noteworthy. Reasons for postnatal anxiety were consistent with research findings in that they related to adaptation difficulties and disappointment with the motherhood experience in comparison to expectations or ideals (Highet et al 2014). Jessica’s words: ‘…..there’s all this hype around how important it is to do it right, and erm, from books from TV and radio…..’ exemplifies the pressure she (and others) felt to ‘measure up’ to others ideals of motherhood. Ways in which women had difficulties adapting to motherhood and felt inadequate in their role have also been described in Section 6.3.5 of this thesis. Improved carer support has been recognised as key to addressing anxiety (Wardrop and Popadiuk 2013, Coates, Ayers and de Visser 2014). Therefore ways in which carers can develop their supportive style and skills to reduce women’s perinatal anxiety are important. Women in this study experienced a great deal of anxiety and also indicated that it led to a real need for compassion from midwives. Furthermore, they provide many examples of how care from midwives (which they perceived as compassionate) relieved their anxiety.

7.8 Compassion Made a Difference

Compassionate midwifery made a positive difference to almost all of the women in this study and their experiences have been captured in the theme: Compassion Made a Difference in Section 6.8 of this thesis. This theme represents the other side of women’s need for compassion or suffering because it encapsulates the ways in which their suffering was reduced by compassion. Given that most women discussed their anxiety in the context of needing compassion, the fact that women linked compassionate care to reduced anxiety and increased feelings of safety is a particularly important finding. This study demonstrated that women experienced compassion from midwives as an intervention which made them feel safer, less anxious and more able. For women, this suggests that compassionate midwifery has the potential to be an effective tool with which to address anxiety and feelings of inadequacy and make women feel safer and more able.

This theme highlights the importance of compassion to women around childbirth and the importance of this study in identifying and describing the experience. Importance not just in identifying and describing what it is but that it makes a difference to women. It illustrates that for the women in this study it was not an embellishment to care, it was, in itself, effective care. This finding raises the discussion on compassionate midwifery
to a new level. If, as this study indicates, it is an effective intervention for decreasing women’s anxiety, increasing their sense of safety and belief in their own ability, it should now takes its place as an essential aspect of midwifery care. This means that compassion as an essential midwifery skill or approach should be non-negotiable. Nevertheless, while the case has been made for compassion to take its rightful place in midwifery care, some exploration of how and why compassion works in this way warrants further analysis.

To the researcher’s best knowledge there is no previous research on compassion in maternity settings, therefore the way that compassion makes women feel safer and more able is not fully understood. However, women’s lived-experiences in this study provide vital clues. Three possible mechanisms are proposed below which are suggested by the findings of this study. They are: emotional regulation, trust and self-efficacy. However, they are not mutually exclusive and it is possible they might apply in combination and interconnect.

7.8.1 Emotional Regulation
Clues that compassion from midwives (at any point in the pregnancy, birth or postnatal period) helped to regulate women’s emotions are evident in some women participant’s narratives. This was particularly evident for Jessica and May who had both experienced stillbirths in previous pregnancies. Additionally, feeling emotional and emotions being ‘all over the place’ (Jess) was common with other women. A midwife’s ability to just be with the woman when she is upset or distressed seems to provide a supportive space in which the woman can be heard and accepted. There were several quotations from women which demonstrated the role that midwives had in helping women to feel seen, heard and emotionally contained at this time. This builds on Reiger and Dempsey’s (2006) work linking emotional support for birthing women to emotional containment, by highlighting how women perceived this as compassionate midwifery because it helped them to cope with their distressing emotions. Similarly, the superordinate theme Relationship provides examples of how the development of a close, authentic relationship in which women felt genuinely cared for and nurtured was experienced as having similarities to a kinship relationship or friendship. There is a well-established link between the way mothers and other carers relate to babies and small children and the development of emotional regulation (Rutherford et al 2015). Mothers can attenuate distress in babies and children and influence their emotional regulation through warm, close relationships and a calm compassionate approach.
(Morris et al 2017; Duncan, Coatsworth and Greenberg 2009). It is possible that the same mechanism that enables mothers to soothe their babies is the pattern for midwives to help soothe women during and around childbirth. MacDonald and Macdonald (2010) identified a contentment, soothing and affiliative focused system in humans which is linked to oxytocin function that has evolved to respond to attachment type behaviour. While usually associated with mother-baby attachment, activation of this soothing system reduces threat responses like fear and anxiety in adults too. This theory has been developed and utilised in psychological therapies with children and adults (Gilbert 2014 and 2015).

This psychological soothing mechanism is consistent with many of the behaviours that women identified as compassionate in midwives and with the concept of mothering-the-mother. It would provide an explanation as to why women sometimes felt that compassionate midwives were like mothers or behaved in a motherly way. This finding is consistent with the evolutionary model of compassion which was outlined in Section 3.3.2 in which compassion is seen as rooted in parental caring behaviour in humans and other animals. It is supported by studies in psychology which link compassion (as caring behaviour) to therapeutic benefits including emotional regulation (Gilbert 2014). The possibility that women might feel infantilised by this was not born out by this study, perhaps because compassionate midwifery involved midwives tuning-in to women and was built on respectful, equal relationships. Moreover, it was also because compassion was a response to women’s suffering and it met their particular need for compassion.

However, a mothering approach may not be beneficial or acceptable for other women, or for other circumstances. It may be unacceptable to women when no need for compassion exists. Therefore this is another example of the complexity of compassion. It is important to understand that all aspects of compassion (being with, relationship, and empowerment) are dependent on each other. If approached in a piecemeal way or misjudged, mothering-the-mother could be perceived as patronising and disempowering.

7.8.2 Trust
The development of trust was part of women’s lived-experience of compassion. Compassion appeared to increase women’s trust in their midwife, the maternity service and themselves. Trust led to them feeling safer. Consequently, women in this study felt more inclined to share their concerns with midwives they trusted. Work by Lewis (2015) depicted midwife-mother trust as an evolving concept that develops over time. Initially it
is associated with the assumed competence of the midwife. However, Lewis found while initial trust was associated with assumed competence, trust deepened and developed over time and became reciprocal. This study on compassion and Lewis’s study on trust have some common ground regarding trust within woman-midwife relationships. However, women’s perceptions of initial trust were different. In this study women did not describe initial trust in the midwife’s competence. Instead, it was ‘…..an instinctive trust…’ (Jennifer); they could, very quickly, recognise something in the way that the midwife was with them which fostered trust, as described in Section 6.4.

Professional competence was a part of this but it was felt or observed rather than assumed. However, as with Lewis’s study trust in the midwife contributed to women’s feelings of safety. Women in this study perceived midwives’ behaviour that fostered trust as compassionate because it reduced their suffering, particularly in terms of reducing their anxiety and made them feel safer. For this reason compassionate midwifery must incorporate the ability to gain women’s trust.

7.8.3 Self-Efficacy

Most women in this study experienced compassionate midwifery care as something that led to them feeling more capable and more empowered. They described how midwives provided information and used teaching and coaching in a way that they found compassionate and this seemed to increase women’s self-confidence in their bodies or in their role as mothers. Imogen spoke of her midwife ‘….really boosting my confidence….’ and Esme spoke of her midwife who: ‘….. really kind of empowered me…..just gave me a lot of confidence to kind of go for it…’ Women recognised themselves getting more confident as a result of midwives who provided support, information, teaching and coaching and they perceived this as compassionate because it was an intervention that addressed their suffering in terms of their lack of confidence in themselves and feelings of inadequacy in their role as birthing or new mothers.

Bandura’s (2012) concept of self-efficacy, (originally proposed in 1991), may be helpful in this respect. A woman’s perceived self-efficacy is her belief in her own capabilities. Stronger birth self-efficacy beliefs predict decreased pain and distress in labour because women believe they can cope with labour (Berentson-Shaw, Scott and Jose 2009). Similarly, women in the postnatal period will feel less anxious and more positive if they have high levels of self-efficacy because they believe they will be able to cope with motherhood. Bandura’s model states that the most effective way of increasing self-efficacy is through mastering a task, role or situation. In this study women experienced
compassionate midwives supporting them (when they felt anxious, vulnerable and unprepared) to master or overcome the challenges of childbirth and mothering. It is feasible that compassion from midwives (particularly as in the finding: Empowerment) helped women to feel safer because it helped them to feel more confident in their body and in their role.

7.9 The Compassionate Midwife

In this study women’s stories of compassion have not only built up an understanding of their lived experience, they have described compassionate midwives from their perspective. The model in Figure 7-2 based on the study findings, proposes an explanation of how compassionate midwifery is experienced. Women’s experiences of the midwife being with them, building relationships with them and acting to empower them are the ways in which compassion is experienced and as such they can be utilised to begin to consider the midwife’s position. All the aspects of compassionate midwifery, uncovered in this study, require the midwife to have considerable skills and attributes. The critical debate in this chapter has argued that emotional intelligence, clinical knowledge and competence are all needed. In addition, they require the motivation and courage to make authentic human connections with women, connections in which women feel that they are on their level and genuinely care about them. These are fairly demanding specifications in themselves. Furthermore, in this model the midwife has to be able to do this in the world in which they live and work. As discussed in 7.6. This world consists of different philosophical positions and contains competing or conflicting demands, ambiguities and paradoxes. Women participants had an awareness of some of these, for example they noted that although midwives had a familiarity with birth, they were able to balance this by honouring the unfamiliar, life-changing ‘big deal’ it was for them. They also saw how compassionate midwives balanced their compassionate care with the work of the NHS Trust’s systems. Whilst the women participants had an awareness of ways in which compassionate midwives found the right balance, it is likely that midwives have many other dimensions to balance. For example, the discussion in Section 7.5 suggests that they need to be able to balance the personal and professional aspects of themselves that they bring to their role. Midwives are also involved in balancing their care within the biomedical and holistic models of maternity care (Hunter L. 2006). Arguably, now more than ever, this ability to achieve a balanced position is needed as polarised ideologies about care
amongst maternity HCPs have been exposed as a major risk to safe maternity care (Kirkup 2015).

Although this study does not describe the midwives’ experience, only the women’s perspective, the findings may say something important about the midwives. They point to other potential demands on midwives. For example, the nature of the compassionate relationships that women experienced discussed in 7.4.2 would appear to call for careful balancing of women’s need for kin-like relationships and the professional relationship demanded by their professional position. It would appear that the personal specifications for a compassionate midwife are demanding to say the least.

The model in Figure 7-2 indicates the fine balancing act that midwives need to maintain to be able to relate to women with compassion. Importantly, there appears to be very little margin for error in this balancing work and the midwife is depicted as the fulcrum or balance point on which all the other elements of compassionate midwifery are supported. Moreover within this conceptual model, it is clear that any factors which threaten midwives’ ability to do balancing work, would de-stabilise the being with, relating and empowering which make up the sphere of compassionate midwifery. In this study, women were highly aware of midwives who were unable to balance the work of the system with meeting their personalised needs as critically argued in Section 7.6.3. With these midwives they described feeling like they were ‘on a conveyor belt’ or that the care was ‘tick-boxy’. Mechanical, production line care has been highlighted in the literature (Shallow, Deery and Kirkham 2017, NHS England 2016) and Hunter’s research (2010) found that this approach placed constraints on midwives’ ability to carry out emotion work. This study goes some way to explaining why women in this study appeared to think of this type of care as the opposite of compassionate.

Importantly, this study cannot reveal whether the compassionate midwives women described from their individual experiences, were able to meet women’s needs for compassion at all times, in all circumstances, to all women and other people. The potential for imbalances suggested by the precarious balancing model in Figure 7-2 would suggest that this is unlikely. Midwives are only human and although it is possible that some midwives are much more adept at balancing work than others, how they feel in themselves is highly likely to have an influence. Midwives have anxieties, pain and lack confidence. In other words, midwives suffer too and therefore need compassion too. If this is the case their own health and wellbeing and systems of support must
surely be key to the concept of compassionate midwifery. Whilst there is an ongoing interest and debate on the subject of resilience in healthcare (Crowther et al 2016, Hunter and Warren 2014, Kirkham 2017) there is wide agreement that resilience is not about midwives toughening up and getting on with job no matter what. Moreover, organisations could do much to support compassionate midwifery. Looking at the model in Figure 7-2 it is easy to imagine the effect that changes to workload, policy and working conditions could make on a midwife’s ability to hold compassionate care in the balance. Organisational factors which act as barriers to compassionate care have been identified in other areas of healthcare (Christiansen 2015). Using the study findings to frame the compassionate midwife offers some insight into the specific barriers to compassionate midwifery. Further research with midwives could test the model from the midwives’ perspective and explore some of ways that midwives manage to sustain compassionate care.

7.10 Limitations of Study

Methodological issues in this thesis have been critically examined in Section 7.2 and strengths and weaknesses debated. In summary, the weaknesses of this study were:

- The size of the study was small, although not small in comparison to other IPA studies. Therefore caution should be taken when considering how the findings of this study can be transferred to other women. However, the small sample size is somewhat offset by the rich depth and detail in the data which led to the novel findings.

- The sample of women participants represented a fairly homogenous group in terms of ethnicity, social class and location. All women lived and had maternity care within The Midlands in England, in the UK. Therefore, applicability and transferability to other women in other areas will need to be considered against this.

- The researcher was also a midwife and this will have influenced the participant/researcher interactions. While the advantages of being both researcher and midwife have been discussed in Section 7.2 it is also possible that women may have adapted their accounts in response to the researcher because she was a midwife by profession. Use of a relaxed and informal interview style and a reflexive approach was used to counterbalance this risk.
7.11 Summary of Discussion

This chapter began with a reminder of the overall aim behind this study. The methodologies used to address these were critically debated in terms of their success in meeting this aim. The combination of describing the concept of compassionate midwifery through a concept analysis and then seeking to understand the lived experience of women through IPA was considered. This novel mixed methodological combination was successful in providing two linked but different facets of compassionate midwifery, the concept in the wider world and the lived experience of the individual women’s inner world.

This inner world, lived experience from the seventeen women in the study informed a new model in Figure 7-2 which depicts the different elements of compassion from midwives and the relationship between them. In this model the themes: being with me, relationship with me and empowering me are depicted as a dynamic sphere, held in balance on a fulcrum point and managed by the individual midwife. The model proposes that compassionate midwifery is experienced when midwives are able to maintain these elements of compassion in the face of philosophical, environmental, cultural and professional incongruences.

The discussion critically examined each element of the model in turn to deepen understanding. A strong argument was put forward, that compassionate midwifery was a welcome and effective response to suffering (for women in this study) helping women to feel less anxious and more able. It therefore represents a powerful intervention for women during pregnancy, childbirth and the postnatal period. The characteristics of the compassionate midwife were also considered in view of the required combination of skills and attributes suggested by the new model in Figure 7-2. Finally, the limitations of the study were listed. The next chapter will focus on the implications for midwifery practice.
Chapter 8 Implications, Recommendations and Conclusions

Qualitative research findings are not generalizable, but they may be transferable to different areas and applicable in different scenarios. Midwives should consider the area in which they practise to make a judgement on whether these findings could inform their care.

The study’s importance is justified in relation to its significance, use and application. Its significance as a concept has been justified because compassionate midwifery as a concept is underexplored in the midwifery literature, yet this study has shown that it is not nebulous healthcare speak. On the contrary, it is a significant aspect of care for women during pregnancy, birth and the postnatal period. Its significance to the women in this study was evident. They recognised when it was happening, and they could describe examples of it and make sense of it in the context of their suffering or distress. Moreover, it made a difference to them; it relieved their suffering by increasing their feelings of safety, trust and helping them feel more able to cope.

Compassionate midwifery care is required by midwives’ professional code and needed by women, therefore the findings of this thesis provide a valuable resource for education, practice and policy. Indeed it may provide the only resource on compassion in midwifery which is both research based and informed by women service users. The ways in which these findings should inform midwifery practice, education and policy are presented below.

8.1 Recommendations for Practice, Education and Policy

Firstly, the concept analysis breaks down the concept into separate but inter-related parts which can be used in the education and preparation of midwives. By breaking compassion into its constituent parts, the building blocks of compassion can be identified and studied. This should involve the different aspects of compassion depicted in the model in Figure 3-3: Recognition, Connection, Motivation and Action as learning areas. This could lead on to activities which support students to rehearse and refine these specific ways of being, and the skills which contribute to them, in a variety of scenarios. An example of this might be active learning around recognition of suffering through the attributes of authentic presence, listening and noticing. Small group work and role play in a safe and supported environment would be ideal for this sort of learning experience.
The findings, on the other hand, represent the lived-experience of women and as such provide insights which will be useful for both student and practising midwives. Compassion as an effective response to women’s suffering which was clearly highlighted in Section 6.3 and Section 6.8, indicates that compassionate midwifery is an important intervention for women around childbirth, helping them to feel safer and more able. The impact of this should not be underestimated. Recognition of suffering is a key skill for compassionate midwifery and should now be demonstrated in all areas of midwifery.

This study’s findings provide insights into midwives’ approaches, skills and behaviours which contribute to compassion and therefore assists all midwives who seek to develop their skills in this important area of care. The Theme Being with Me provides a rich source of material on compassionate midwifery practice. The findings suggest that such practice may be very teachable and should be developed through pre-registration midwifery courses. Sessions that incorporate communication skills and basic counselling skills should be essential parts of midwifery preparation but they should focus on listening, sensitivity, observational skills. There should be an understanding of how sometimes saying less and doing less when attending a distressed woman may in itself be a compassionate and therapeutic act. Learning outcomes must reflect the value of these skills in developing compassionate care through enabling midwives to feel comfortable and confident to stay with women in their suffering. Increased understanding of this for qualified midwives should also be encouraged and supported. This might come from professional development activities and should be supported by management and by the models of supervision within the workplace e.g. Professional Midwifery Advocates in the UK’s new model of supervision (2017 NHS England).

Moreover, given that, for women in this study, experiencing compassionate midwifery made such an impact, it is worth considering which women might benefit most from compassionate care. Compassion is a response to suffering, therefore women who are known to be suffering may be most likely to benefit the most from compassionate midwifery. This is not to say that compassion should be rationed in any way, but rather that compassionate midwifery is an intervention that may make a big difference to women in particular circumstances. Therefore, there should be a strong focus on compassionate practice with particularly vulnerable or anxious women, for example those with mental health problems, previous trauma and women who find it difficult to trust HCPs.
The importance of the theme *Relationship* as part of compassionate midwifery was evident in Section 6.5 of this thesis. All midwives and those managing and leading maternity care should reflect on this finding and ascertain how they can play their part in supporting compassionate care through relationship-based care models. Professional bodies, maternity care organisations and individual midwives should reflect on how these findings add weight to the call for continuity models of midwifery. In the UK, implementing Better Births (NHS England 2016) provides a strategy for achieving this. However, given that women in this study saw their relationship with a compassionate midwife as like a kinship or friendship, professional bodies urgently need to review their guidance on woman/midwife professional relationships. A serious debate should be conducted on this matter in order to develop new guidance for midwives. Such guidance should acknowledge and reflect the emotionally close relationships inherent in compassionate care and enhanced by continuity models of care. Midwifery policy now needs to move forward and reflect the social models of care that are needed for compassion to flourish.

The theme *Empowerment* identified in Section 6.6 supports the need for midwives to be self-aware and understand the communication styles that best express compassion, especially in relation to providing information and teaching and coaching activities with women. Opportunities should be provided for student midwives to practice informing, teaching and coaching activities using communication styles highlighted by the women participant’s in this study. In particular providing women with professional information not just without a superior approach, but in the style of a friendly peer, seems to be key to compassionate communication. Closer attention to language around childbirth and the use of empowering, yet normal, easily understood language would appear to be an important aspect of teaching compassionate midwifery care.

The theme *Balance* in Section 6.7 and the way in which balance supports all the other aspects of compassionate midwifery is depicted in the model in Figure 7-2. Midwifery educationalists and leaders should explore the concept of balance and consider its implications when recruiting and selecting student midwives. The midwife balancing outlined in Section 7.6 and depicted in the model in Figure 7-2 indicates the very difficult balancing act that midwives need to achieve if they are to be in a position to practice with compassion. This key aspect of compassionate midwifery may be particularly difficult for midwives who are themselves vulnerable or anxious. Midwives are increasing experiencing stress, burnout and anxiety both in the UK (Hunter and
Henley 2018) and in other countries (Creedy et al 2017). Midwives should be encouraged to reflect on what impacts on their ability to balance compassionate care.

For educationalists there are some tricky, yet fascinating, questions to ask. For example: how do midwives develop compassionate wisdom? How can the ability to be comfortable with contradictions or paradoxes be taught? For midwives the ability to balance compassionate care may be highly sensitive to midwives’ experience of wellbeing. Healthy working practices may be important and personal practices that support wellbeing like mindfulness and meditation may be useful but require further research. Good peer support and leadership which seeks to empower midwives is also likely to play a vital part.

Midwifery managers and commissioners of maternity services will find this study valuable. As they strive to provide both safe and compassionate services within a resource-stretched NHS, these findings may provide important messages. Compassionate care does not require huge resources and yet it makes a positive contribution to care. Those who design and lead maternity services could start by considering how the organisational structures and systems in which midwives care for women could support the sort of compassionate care described in this study. Opportunities to build relationships through continuity of care models may be an obvious place to start and recent recommendations in England to move to continuity models has the potential to support this aspect of compassionate care (NHS England 2016). For the profession there are some even more difficult issues. Given that women saw compassionate midwives as being on their level and like friend or family, professional boundaries may need to reflect this by being more nuanced. Women in this study wanted midwives to be human and professional. If the profession is serious about compassion it will need to provide the professional structure and guidance to encourage and support that.

Compassion should become embedded in all aspects of midwifery education, practice and policy as outlined above and summarised below in Table 8-1. To support this, the knowledge, skills and values that are needed for compassionate practice to flourish, must be fully explored. The Model of Compassion in Balance shown in Figure 7-2 indicates the complexity for midwives who need to demonstrate care around being with, relationship and empowerment and simultaneously maintain multi-dimensional balance. Therefore the personal, professional, environmental and organisational
factors that enhance and restrict compassionate practice need to be fully understood and acknowledged, not only by the midwifery profession but by those who commission and lead maternity services.
Table 8-1 Implications and Recommendations for Midwifery Practice, Education and Policy

<table>
<thead>
<tr>
<th>Finding</th>
<th>Implications and Recommendations for Practice</th>
<th>Area of Midwifery</th>
</tr>
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<tbody>
<tr>
<td>Concept Analysis</td>
<td>Describing the concept of compassionate midwifery as a process with four parts should contribute to: Learning about the complex nature of compassion (it is more than one thing) Considering and practising ways of showing compassion: different aspects can be used as a framework for designing communication skills activities, particularly role play and feedback activities</td>
<td>Education</td>
</tr>
<tr>
<td>Compassion as a response to suffering (Themes 1 &amp; 6 of study findings)</td>
<td>This finding indicates that compassionate midwifery is an important intervention for women around childbirth, helping them feel safer and more able. Midwives should develop skills in the key areas of compassionate practice identified. There should be a strong focus on compassionate practice with particularly vulnerable or anxious women, for example those with mental health problems, previous trauma and women who find it difficult to trust HCP. Recognition of compassion as a key midwifery tool should now be demonstrated in all areas of midwifery</td>
<td>Practice, Policy, Education, Practice and Policy</td>
</tr>
<tr>
<td>Being With Me (Theme 2 IPA study findings)</td>
<td>This aspect of compassionate midwifery may be very teachable and should be developed through pre-registration midwifery courses that include participative communication skills sessions with feedback. These should focus on listening, sensitivity, observational skills and basic counselling skills. There should be an understanding of how saying less and doing less when attending a distressed woman may in itself be a therapeutic act. Midwifery learning criteria should reflect the value of these skills to enable midwives to stay with women in their suffering Increased understanding of this for qualified midwives could come from professional development activities and should be supported through clinical supervision. Moving away from a culture of tasks and business to a culture of support.</td>
<td>Education, Practice, Policy</td>
</tr>
<tr>
<td>Theme</td>
<td>Findings</td>
<td>Implications</td>
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<td><strong>Relationship</strong> (Theme 3 in IPA study findings)</td>
<td>All midwives and those managing and leading maternity care should reflect on this finding and think about how they can support compassionate care through relationship-based care models. Professional bodies, maternity care organisations and individual midwives should reflect on how relationship is key to compassionate care and how these findings add weight to the call for more continuity in maternity care. Implementing Better Births provides a strategy for reaching this aim. Professional bodies need to review their guidance on professional woman-midwife relationships. Findings from this study show that women saw their relationship with a compassionate midwife as kinship-like or friendship-like. Guidance which reflects the emotionally close relationships inherent in compassionate care should be developed. This should include guidance on ending or continuing relationships after women's discharge from maternity care.</td>
<td><strong>Practice and Policy</strong></td>
</tr>
<tr>
<td><strong>Empowerment</strong> (Theme 4 in IPA study findings)</td>
<td>Emphasis on social models of care. Awareness of communication styles which underpin compassion especially in relation to providing information and teaching or coaching activities with women. Opportunities for student midwives to practice informing, teaching and coaching activities using communication 'in the style of the friendly peer'. Closer attention to language around childbirth. Use of empowering language which is 'normal' language and easy to understand.</td>
<td><strong>Policy, Education</strong></td>
</tr>
<tr>
<td><strong>Balance</strong> (Theme 5 in IPA study)</td>
<td>Midwifery educationalists and leaders need to explore this concept and consider its implications for recruitment and selection of student midwives. This key aspect of compassionate midwifery may be particularly difficult for midwives who are themselves vulnerable or anxious. Midwives are predominantly young women and increasingly young women are experiencing anxiety, depression and other mental health problems. Achieving a sense of perspective and balance may be supported at the individual level by mindfulness techniques, peer support and working practices that empower midwives.</td>
<td><strong>Education, Policy</strong></td>
</tr>
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8.2 Recommendations for Further Research

This qualitative study has provided rich insights into women’s lived-experience of compassionate midwifery care within two NHS systems in The Midlands. While these insights have significance, value and applicability to practice, they also raise more questions. The researcher believes that this is the first study of its kind in the field of midwifery so it follows that further research is important to build on this. In accordance with IPA methodology, the women in this study were a relatively homogenous group. Therefore, this study should be repeated with different groups of women for example single mothers, women who are experiencing poverty or women who have drug or alcohol problems. Additionally, the study should be repeated in other parts of the UK and in other countries to build a broader understanding of compassion within diverse societies and cultures. An understanding of the experience of compassion for women in a diverse range of settings and cultures would build a comprehensive understanding of the features of compassionate midwifery that are culturally specific. Tea as drawn out in the thesis is a good example of this but it may be replaced by other symbols of compassion in other cultures, for example, where tea is not commonly drunk. Moreover, the features of compassionate midwifery that cross all borders would be identified. It is possible that there are aspects of compassion that are common to all women, perhaps the ability to Be With women in their suffering is a feature of compassion for all women but this needs to be ascertained through research. A study to explore this would be extremely valuable as it would have the potential to indicate if something akin to an international language of compassionate midwifery exists which would be relevant wherever midwives are working with women. The power of such an intervention for women migrants, for example, away from the familiarity of their own family and home, is potentially huge.

Compassionate midwifery from the perspective of others is a valuable subject for further study because the views of partners and other family members provide a different yet relevant perspective. There is evidence of partners’s fear and distress during childbirth (Johansson et al 2012) and therefore their need for compassionate care from midwives should be a focus for future studies. Only by developing an understanding of compassionate midwifery from all perspectives, can it be understood in its entirety.
Importantly, midwives’ perspectives on compassionate care need to be explored. This could be undertaken with a similar study design and starting with a blank canvas by asking them: What is your experience of compassionate midwifery? Key to any study with midwives would be the questions: What motivates midwives to be compassionate? As well as: What factors inhibit midwives’ compassion? Motivation emerged as a feature of compassion in the concept analysis but this study could not address this adequately. Women in the study experienced their compassionate midwives as actually caring for them like a friend or family member. Therefore midwives’ genuine feelings of attachment may account for midwives motivation to act to relieve suffering. However, without uncovering midwives experiences, thoughts and feelings it is not possible to make assumptions on this.

The model of Compassionate midwifery in Balance depicted in Figure 7-2 that came out of this study should now be explored with midwives. The model could be presented to midwives or groups of midwives in focus groups to test the model from the midwives perspective. Obtaining midwives’ views on, and finding out what they think the barriers to this type of care are, would provide much needed information for those interested in facilitating more compassionate maternity services.

The outcomes related to compassion are also areas for further study. Women in this study were clear about the benefits for them. Further exploration for larger groups of women would indicate whether this applies to other women in other settings. However, in the longer term, quantitative studies in which women rate their care, for compassion, using a tool or scale might be possible. To do this a scale would need to be developed and validated first. Such tools exist for use in other disciplines, like nursing (Burnell and Agan 2013; Fogarty et al 1999 and Kret 2011). There are similar tools in maternity care, for example Respectful Care Scale (Sheferaw, Mengesha and Wase 2016). Although respectful care may have some features of compassionate care, this study has highlighted that compassionate midwifery is distinguishable and recognisable as midwives’ supportive responses to women’s suffering. A tool to assess compassionate midwifery care would be of value in expanding knowledge in this specific area. Qualitative studies, like this one, and those suggested above, should be used to inform scale development and guide preparatory work for a quantitative measurement tool. A compassionate midwifery scale which would compare ratings to outcomes such as self-efficacy, breastfeeding, PTSD could be used to investigate the possible effects of compassionate midwifery as an intervention.
What is clear is that this is just the beginning of research into compassion in a midwifery context. It is an important and illuminating start from which a body of knowledge about compassionate midwifery can be developed to underpin professional practice.

8.3 Conclusion

This thesis represents a novel, unique and empirical investigation into the meaning and the lived experience of compassionate midwifery for women around childbirth. Whilst the Concept Analysis identified it as a process, the IPA study highlighted it as a midwife’s response to their suffering, which made a positive difference to them. It made them feel safer and more able. Compassion built trust, reduced anxiety and this helped women feel safe. A woman who feels safe is safer; she trusts her midwife and knows that she will get a compassionate response from her. She will feel safe enough to discuss her problems, she will feel safe enough to ask for help and trusting enough to accept help. She will feel more empowered to cope with the pregnancy and the birth and life with a new baby.

The study findings identified four themes which depicted women’s experiences of midwives’ expressions of compassion and the model in Figure 7-2 proposes the way that these themes work by being maintained in a state of balance. The way that midwives attended to, related to and empowered women is depicted in this model as a dynamic sphere. These aspects of compassion have some similarities with the literature on the qualities of a good midwife and good midwifery care. Therefore, it seems likely that compassionate midwifery has always been an integral part of quality midwifery care and vice versa.

However, in this study there were some novel differences gleaned from women’s accounts of midwives’ approach and style. These add depth, detail and nuance to what was previously known. One of the most important of these was that women experienced their relationships with compassionate midwives as similar to kinship or friendship relationships, reflecting an emotional closeness which women experienced as genuine caring. This has implications for professional behaviour and boundaries. Moreover, while women embraced such relationships with midwives they also wanted them to share their professional knowledge and expertise in ways that empowered them and what made this compassionate, was sharing it in a non-hierarchical, ordinary way. In essence, the sharing of professional expertise in the style of a caring peer
empowered women by bypassing traditional power imbalances. This is an exciting and useful finding because women need to feel powerful around childbirth in order to birth their babies and take on the commitment and responsibility of mothering. Ways in which midwives can act to empower women are therefore fundamental to supporting women around childbirth.

The relationship between the expressions of compassion from midwives and the balancing that is necessary to support these (Figure 7-2) is perhaps the most interesting and surprising finding. It uncovers midwifery qualities which until now, have been barely acknowledged, let alone developed or assessed. They suggest an approach which goes so much further than any of the current, official midwifery competencies. The ability to balance and even embrace, competing or conflicting demands, ambiguities and paradoxes, a potential source of stress, suggests a particular philosophical approach to life or a form of compassionate wisdom. Furthermore, this fulcrum of balance which underpins compassionate midwifery may be vulnerable to other influences which threaten it. Understanding more about how midwives’ achieve and maintain the ‘balancing act’ that underpins compassionate care and what personal and environmental factors support it, will be the key to sustaining compassionate midwifery in practice.

This study has fulfilled its aim of gaining an understanding of the lived experience of compassionate midwifery. It represents the very first piece of work in this area, but it must now be built on. Compassion in midwifery is not a fashion, fad or a buzz-word. It is a powerful intervention for women which reduces suffering, helping them to feel (and therefore be) safer and more able. Compassion has been a part of the rhetoric in midwifery for years but as a hazy and ill-defined concept it remained just that: rhetoric. This study has increased understanding and built the foundations for compassionate midwifery to flourish and grow. In the final analysis, it has identified that rhetoric is not enough. Above all it is hoped that the findings of this study mark an end to compassion being little more than a platitude in midwifery. Compassionate midwifery is out there in practice, it happens, and when it does, it is easily recognised and described by women who need it and feel its benefits. It is time to move forward with compassion.
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Chapter 10 Appendices

10.1 The ICM International Definition of the Midwife

“A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

Scope of Practice
The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.”

Adopted at Brisbane Council meeting, 2005
Revised and adopted at Durban Council meeting, 2011
Revised and adopted at Toronto Council meeting, 2017
Due for next review 2023
10.2 Leaflet/poster

Compassionate Midwifery Care

What does it mean to you?

Have you had care from a midwife or midwives who treated you with compassion? Would you tell us about it? We are conducting research into this subject and would like to hear about your experience.

If you are pregnant or if you have had a baby in the last 4 weeks and you think that you have experienced some compassionate midwifery we would like to talk to you. Please text or email us with the word ‘compassion’ and our researcher will contact you to discuss what is involved with no obligation.

Please text or email now
Researcher’s Name: Diane Ménage
text 07493611830 or email menaged@uni.coventry.ac.uk
Women want to be treated with kindness and compassion during pregnancy and childbirth. However, what this actually means to the women using maternity services has never been studied. This project will aim to do just that. The researcher wants to hear about real, examples of compassionate midwifery to gain a deeper understanding of how women experience compassion from midwives. The compassionate care could be during pregnancy, labour or after you had a baby. It could have been at an antenatal clinic or surgery, or at a hospital, birth centre or at home. The findings of the research could help to develop more compassionate care for women and babies. Sharing your experience could be a valuable part of this process.

Who am I and what is my background?

My name is Diane Ménage and I am an experienced midwife and a PhD student with the Children and Families Research Team (CFR) team at Coventry University. Other members of the project team are Professor Jane Coad, Dr Elizabeth Bailey and Susan Lees. I will be interviewing women in the Coventry and South Warwickshire area in spring and summer of 2016.

Some Frequently Asked Questions

Do I have to take part?
No it is completely voluntary. If you don’t want to be included in this study don’t do anything. If you do agree to be interviewed you can still withdraw from the study if you change your mind.

**What I have more questions?**

If you have some questions about the study that are not covered here please feel free to text, phone or email me so that I can answer them.

**Where will I be interviewed?**

I can come to your home at a time to suit you. Alternatively if you prefer I can arrange to see you at another place, for example a private room at the hospital. If a face-to-face interview is really not for you then I can arrange to interview you on the phone or on Skype or you could write down your experiences.

**How long will it take?**

Approximately 30 – 50 minutes. If you have just had a baby I appreciate how difficult it can be to plan anything and I will be very flexible and fit in with you and your baby’s needs. I understand that the needs of your family come first and I can work around that.

**What will happen at the interview?**
I explain the process to make sure you understand everything before asking you to sign a consent form. I will ask you about your experience. We will have an informal conversation about your experience of compassionate care from a midwife or midwives. I will be interested in what happened and what your thoughts and feelings were. I will make an audio recording of the interview so that I don’t need to make written notes during the interview and can listen to you.

**What will happen after the interview?**

After the interview I will use the audio recording to make a written record of it. The audio record will be then by destroyed. To ensure your anonymity I will give you a false name or pseudonym. I can choose the pseudonym or you can choose one yourself if you prefer.

The interviews will then be analysed and the findings will form part of my PhD thesis. Findings will be shared with midwives and made available through academic papers and professional conference presentations.

**Will other people be able to read or hear what I said at the interview?**

Your information will be stored securely and treated as confidential. Only me (as the researcher) and the three named members on the project team will see the data from interviews. The final research report and related documents may contain some selected quotes from some interviews but these will be anonymous through the use of pseudonyms.

**What if I have other questions?**
Please don't hesitate to email me (or phone if you prefer) with any other questions.

If I am happy to take part what do I do now?

Just text me on 07493611830 or email me at menaged@uni.coventry.ac.uk to say you are happy to be interviewed and I will contact you to arrange a day and time which will be convenient for you.

What are the possible disadvantages and risks of taking part?

This is a low risk study of women’s experiences of compassionate midwifery care. It is not envisaged that taking part in the study will have significant disadvantages or particular risks. However, if a significant problem or health need is brought to my attention during the study I will seek your consent to refer you to an appropriate professional or service.

How do I make a complaint?

The research team do not believe that anything will go wrong. However, if you wish to complain about any part of the study please contact Professor Ian Marshall, Deputy Vice Chancellor, Coventry University, Priory Street, Coventry, CV1 5FB i.marshall@coventry.ac.uk The matter would then be followed up via the University complaints procedure.
Informed Consent Form

1. I confirm that I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions. Please initial □

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. □

3. I understand that all the information I provide will be treated in confidence. □

4. I understand that I also have the right to change my mind about participating in the study for a short period after the interview has concluded (10 days). □

5. I agree to be audio recorded as part of the research project. □

6. I understand that anonymised quotes from the interview may be used in the researcher's PhD thesis or in academic papers reporting on the research. □

7. I agree to take part in the research project. □

Name of participant: ....................................................................................
Signature of participant: ..............................................................................
Date: ...........................................................................................................

Name of Researcher: ....................................................................................
Signature of researcher: ...............................................................................
Date:
10.4 Signposting Protocol for Compassionate Midwifery Study

Protocol for signposting or referring to services or support in the event that a woman or baby has a significant problem or need during the research process.

The researcher will interview women about their experiences of care from midwives. Although the aim of the research is to gain an understanding of positive experiences of compassion, the researcher recognises that talking about pregnancy and birth can sometimes be an emotional and sensitive subject. The researcher is a qualified and experienced midwife and will deal sensitively with women at all times. The researcher will avoid offering midwifery advice or care when in contact with women during the study. The researcher will only provide midwifery care in the event of an emergency. However, if she notices a significant problem or need (mother or baby) and she is not satisfied that this is already being dealt with she will make appropriate and timely referral to the appropriate health care professional or service.

These may include

- Ambulance
- GP
- Community Midwife
- Health Visitor
- Perinatal Mental Health Team
- Clinical Psychologist
- Social Services
- Supervisor of Midwives
- Trust Complaints procedure
- Birth listening service
- Head of Midwifery or Operational Manager (if a process related concern)

Prior to recruitment of participants the researcher will ensure that she has contact details for all the above.

Diane Ménage  10/02/2016
### 10.5 Transcription Notation

<table>
<thead>
<tr>
<th>Notation</th>
<th>Signifies</th>
<th>Example within transcription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italics in single quotation marks ‘ ’</td>
<td>The woman participant’s words</td>
<td>‘That’s what I think’s, that’s what made the difference. I felt looked after.’</td>
</tr>
<tr>
<td>Double quotation marks “ “</td>
<td>The woman participant quoting somebody else</td>
<td>‘She just put her hand on my leg and she said “Ok let’s do your bloods now”’.</td>
</tr>
<tr>
<td>Dotted line ........</td>
<td>Word or some words omitted to aid clarity or highlight a part of this account</td>
<td>.... she was very kind especially when we found out</td>
</tr>
<tr>
<td><strong>Bold</strong></td>
<td>The woman’s emphasis when speaking</td>
<td>I felt quite anxious about, more probably <strong>after</strong> the birth</td>
</tr>
<tr>
<td>Normal brackets ( )</td>
<td>Reflect what the woman said and how she said it</td>
<td><em>they’re obviously focussed and concerned (I guess) about the baby</em></td>
</tr>
<tr>
<td>Square brackets [ ]</td>
<td>Researcher note or replacement words</td>
<td><strong>I think it certainly affected how I got on with [name of new baby]</strong> in the first few weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>cos he had no idea</strong> [laughs],</td>
</tr>
<tr>
<td></td>
<td></td>
<td>……..it was ”let’s do it” and it’s done [pause, seems to be thinking]</td>
</tr>
</tbody>
</table>
10.6 Looking for Connections Across Themes
10.7 Glossary

Midwifery Glossary

A-EQUIP (stands for Advocating and Educating for Quality Improvement): Following the end of statutory supervision of midwives in England in 2017, a new model of employer led, clinical supervision of midwives has been proposed, piloted and will be phased in. The model incorporates the role of the Professional Midwifery Advocate (PMA) which will replace the old Supervisor of Midwives (SOM) role. It is envisaged that the PMA will have a supervisory, leadership and advocacy role supporting midwives in their practice.

Antenatal: Before the birth.

Electronic Fetal Monitoring (EFM): A method for monitoring the condition of a baby in the uterus by noting any unusual changes in its heart rate. Electronic fetal monitoring can be performed late in pregnancy or sometimes continuously during labour.

Epidural: A local anaesthetic injected into the lower spine to provide pain relief in labour.

Friends and Family Test: Introduced in 2013 to all NHS acute hospitals in England, it is a very simple ‘test’ or questionnaire with the aim of increasing patient feedback and improving quality of care. The main question is ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’ and respondents can rank their answer from ‘extremely likely’ to ‘extremely unlikely.’ There is also opportunity to prove a follow up comment. Results are published monthly. The test was formally reviewed after the first six months of data collection and subsequently extended to maternity, and other areas.

Induction of Labour (IOL): Artificial methods of inducing labour rather than letting it happen spontaneously. It is a procedure that is offered when risks of the pregnancy continuing are greater than the risks of staying pregnant. These may be risks to the woman or her baby.

Intrapartum During labour and birth.

Midwife-led Continuity Models of Care or Midwife-led Continuity Models: These provide care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period, and it has been shown that many women value this and it is associated with improved birth outcomes. These midwives also involve other care-providers if they are needed. Obstetrician-led or family doctor-led models are not usually able to provide the same midwife/wives throughout. Sandal et al (2016).

Midwife-led Unit or Birth Centre: A place to give birth with an emphasis on birth without medical intervention, where care is led by midwives.

Multigravid: A woman pregnant for the second or subsequent time.

Multiparous: A woman who has given birth more than once.

Neonatal: Relating to the new-born. Usually pertains to the first four weeks after birth.
**Nursing and Midwifery Council (NMC):** The NMC is the regulator for nursing and midwifery in the UK. It maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK. It regulates nurses and midwives in England, Wales, Scotland and Northern Ireland. The NMC set standards of education, training, conduct and performance for nurses and midwives.

**Perinatal:** The time around birth (before and after).

**Postnatal:** After the birth.

**Pre-eclampsia:** A potentially serious condition that affects some pregnant women, usually during the second half of pregnancy (from around 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria).

**Primigravid:** A woman pregnant for the first time.

**Primiparous:** A woman who has given birth once.

**Special Care Baby Unit (SCBU):** A specialist hospital department for the care and treatment of newborn babies that are ill, premature or require some form of special care or monitoring.

**Supervision of Midwives:** A system of supervision for all midwives in UK which was enshrined in law until 2017. In this system every midwife was allocated a Supervisor of Midwives (SOM) and had to submit their *Intention to Practice* document every year. Supervisors were experienced midwives who had undergone extra period of preparation for the role. All midwives had to meet with their SOM at least once a year. SOMs had both a regulatory and a supportive role and this was seen as a conflict of interest. The NMC asked for this system to be removed from the regulatory legislation after a number of critical incidents and independent reports confirmed the previous arrangements were not appropriate for public protection. The Nursing and Midwifery Council (NMC) now has sole responsibility for all aspects of midwifery regulation. A new model of clinical supervision called **A-EQUIP** has been proposed.

**Tocophobia:** A severe fear of pregnancy and childbirth which can lead to avoidance of childbirth. Primary tocophobia is found in women who have no previous experience of pregnancy. Women who have secondary tocophobia are fearful because of a previous birth experience.

**VBAC:** Vaginal birth after previously having a caesarean.
10.9 A Concept Analysis of Compassionate Midwifery

Paper submitted to the Journal of Advanced Nursing

Accepted for publication 2nd November 2016
Some materials have been removed from this thesis due to Third Party Copyright. The unabridged version of the thesis can be viewed at the Lanchester Library, Coventry University.
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