Compassion: an exploration of student midwives' academic and clinical learning during their midwifery education.

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Thesis submitted to the University of Nottingham in part fulfilment for the degree of Doctor of Education

October 2021

Abstract

The appalling failings at the Mid-Staffordshire trust highlighted by Francis in 2013, prompted a renewed focus upon compassionate healthcare. Consequently, compassion and delivering compassionate care, although, not a new concept in midwifery, formal study in undergraduate curricula is relatively novel. Therefore, those responsible for undergraduate courses, have needed to consider how students may be educated about and for compassion. As midwifery education involves practice learning, consideration also needs to be given to this aspect. This presented an opportunity to learn from midwifery students who were about to, or already had been formally taught about compassion and who had spent varying lengths of time in their midwifery practice placements.

A mixed methods approach was utilised and included: data collection via a free writing exercise prior to new students' studying about compassion. Students in all years of the course were surveyed via a self-completion questionnaire, including questions eliciting both qualitative and quantitative data. Finally, focus groups comprising three semi-structured interviews were facilitated separately and with a sample of volunteer students from all years of the midwifery course. Thematic analysis was used to interpret the qualitative findings. Wenger's (1998) Communities of Practice, Social Learning Theory offered a useful lens to make sense of and analyse the data's findings. The quantitative data show to what extent the students reported that being taught about compassion had increased their understanding. Furthermore, it shows how much or how little being taught about compassion had prepared the students for clinical practice

and subsequently to what degree clinical practice had informed their learning about and for compassion.

The results show that the majority of students reported formal study about and for compassion had increased their understanding. The midwifery practice placements also supported students' learning about and for compassion. Therefore, the formal teaching about compassion during undergraduate midwifery education is recommended. Three distinct yet interrelated phases emerged and the findings show that students' brought their pre-professional life experiences to the classroom and clinical practice; they continued to learn both formally and informally, depending upon the situations they found themselves in. These findings have significant implications for students, midwifery educators, clinical midwives supporting student learning and Heads of midwifery who have an overall responsibility for students' practice learning in the maternity services.

Acknowledgments

I would like to express my sincere gratitude to, Professor Christine Hall; Dr Jenny Elliott and Professor Bernadette Youens. Their advice and support was invaluable. In particular, they have given me expert guidance in the field of educational theory. I shall be forever grateful.

Thank-you to the student midwives who participated in this study, without you, this thesis would not exist. My sincere hope is that your education about and for compassion supports you in giving high quality maternity care to women and their families throughout your midwifery careers.

Thanks to the School of Health Sciences for supporting me to do the Professional Education Doctorate (EdD).

Finally, thank-you Mark for your support during the completion of this thesis and the twenty plus years of intermittent study that preceded it.

Disclaimer

Parts of this thesis have been published in the papers below:

Pearson, M. (2018) Educating student midwives about compassion: A critical reflection. **British Journal of Midwifery** 26 (4): PP 1-3.

Russell, K, Pearson, M, Wain, A. (2019) **Delivering Year One of the Bachelor of Science Midwife Programme. A Teaching and Learning Training Manual. For the Association of Indonesian Midwifery Education.** University of Nottingham. AIPKIND.

Some of this thesis has been reworked from the modules submitted during the taught component of the Education Doctorate. I declare this thesis is original and my own work.

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Chapter one

1.1 Introduction

In 2010 the Francis Inquiry was set-up to investigate catastrophic failings in National Health Service (NHS) care provision at the Mid-Staffordshire Foundation Trust between 2005 and 2009. Failings were identified on every level including: individuals, all tiers of the management structure and the regulators (Francis, 2013). The bullying culture and shortage of nurses was cited as the number one cause of the issues, together with a management who failed to acknowledge the ongoing problems at the trust (Francis, 2013). The relatives raising concerns about the patients who suffered and subsequently died as a result of the failings were not listened to. The inquiry judged that between 400 and 1200 deaths could have been prevented (Francis, 2013). The Inquiry report detailed 290 recommendations needed for improvements to NHS care, including that healthcare professionals must provide compassionate care (Francis, 2013). Midwifery care at the Mid-Staffordshire Foundation Trust was not cited in or found to be lacking in the Francis Report. However, the Nursing and Midwifery Council (NMC) recommended that midwifery education should meet the requirements set-out in Francis's (2013) recommendations including those numbered between 185-7, importantly, the value of compassion.

The meaning of compassion is explored more fully in the next chapter, however dictionary definitions offer a useful starting point for thinking about the concept. The Oxford English Dictionary (OED) defines compassion in terms of: '*pity, help and being merciful*', which imply three rather different stances (Thompson 1995, p. 270). Compassion is a generally used and widely referenced term, but it soon becomes clear that nuances of definitions differ, particularly insofar as they

relate to the contexts of different professions (Richardson, Percy et al., 2015 p e-2). Scholars agree that compassion is difficult to define (Saunders 2015, Schantz, 2007, Armstrong, 2006). This means it is difficult to know in a midwifery specialist context if everyone is describing compassion in the same way (Richardson et al., 2015).

Prior to Francis's 2013 report, others had also highlighted how important it is that compassion should be practised by healthcare professionals and those providing care (Gilbert, 2009; Firth-Cozens and Cornwell, 2009; Bradshaw, 2011; Care Quality Commission, 2011; Parliamentary and Health Service Ombudsman, 2011; Keogh, 2013; Darzi, 2008). These reports had indicated the importance of compassion but as the Francis Inquiry demonstrated, had failed to make it an important aspect of healthcare. Lord Darzi's 2008 report included recommendations in, the form of a ten year plan, *High Quality Care for All*, aimed at improving NHS care. This has become known as the 'NHS Constitution' (2009). The Constitution identified six key themes and values that should underpin care, compassion being one of them. The other five are: working together for patients; respect and dignity; commitment to the quality of care; improving lives and everyone counts. In 2012, the Department of Health [DH] produced a vision for healthcare known as *Compassion in Practice.* This proposed that care should be predicated upon the 'The Six Cs': care, compassion, courage, communication, commitment and competence. This further emphasises that, alongside the other five Cs, compassion is a key quality in healthcare.

Whilst midwifery was not cited in the Francis' Inquiry, the profession has not been without scandal and failings in care. The Kirkup Report (2015) highlighted the preventable deaths of mothers and babies due to the unsafe maternity care at the Furness General Hospital between 2004 and 2013. Failings on every level were noted. The failings notably ranged from individuals working on the maternity unit to those responsible for monitoring and regulating the trust (Kirkup, 2015). The recommendations from the report included the timely acknowledgment of errors, appropriate support and the need for monitoring staff knowledge and skills however, the report did not place an emphasis on compassion and compassionate care (Kirkup, 2015). However, the profession's regulatory body, the Nursing Midwifery Council (NMC), issued a revised Code of Conduct in 2015 and this was updated in 2018. This Code sets out that where practice falls short, registrants may be called to account. The Code (2018) is used as a standard to assess an individual's practice. The 2015 and 2018 Code, which replaced the previous 2008 version, stipulates that care must be compassionate; the 2008 Code of Professional Conduct made no mention of compassion (NMC, 2008); highlighting the importance of the value to midwives and prompting a renewed focus for it to underscore all healthcare.

Compassion, perhaps was a quality previously taken for granted in those entering a healthcare profession. Interest in the value has steadily grown both nationally and internationally. For example, the International Confederation of Midwives called for midwifery care to be compassionate (ICM, 2011). In 2016 the Government mandated that Health Education England (HEE) should ensure that universities and trusts recruit students and qualified staff through a Values Based Recruitment (VBR) approach (HEE, 2016).

The HEE stipulates that: *'healthcare staff must have the necessary compassion, values and behaviours to provide person centred care and enhance the quality of the patient experience through education, training and regular continuing personal and professional development, that instils respect for patients'*
(HEE, 2016 p. 30).

As the quotation emphasised, undergraduate education from this point should include teaching about ideas associated with compassion.

This suggests widespread agreement about the importance of educating future healthcare professionals about compassion (Royal College of Nursing [RCN] 2012). However, what form this should take in midwifery is not clear. There is little published work about how compassion might be taught and how it may be learned (Hall, 2013; Menage, Bailey et al., 2016). Research into how to educate for compassion may alleviate some of the challenges that educators currently face when deciding how to support students in developing the skills, knowledge and attitudes conducive in showing compassion. Additionally, sharing that research should help to ensure that concerns about compassion underpinning healthcare will amount to more than simple rhetoric (Pearson, 2018).

The aims of this study are therefore to investigate student midwives' understandings of compassion and the impact that the taught theory and clinical practice elements of their education have upon their learning. This study aims to explore and understand how theory and practice may potentially work together to facilitate student midwives' learning for and about compassion during undergraduate midwifery education. The overarching question for the study is:

What and how do student midwives learn about compassion in an undergraduate midwifery course?

Three sub-questions will be explored to build an answer to this main question

i) What do first year student midwives consider compassion to be before formally studying about it?

ii) How useful did student midwives find studying a module about compassion in changing their understanding?

iii) *How does working in clinical practice influence the student midwives' learning about compassion?*

These research questions are intended to: firstly, frame what the research is about; secondly to provide a periphery and avoid any unnecessary deviances throughout the research development; thirdly guide and focus the literature searching, and fourthly determine who the data should be collected from and how (Bryman, 2004).

As a practice-based profession, learning in midwifery needs both theory and practice, described in 1966 by Polyani as explicit and tacit knowledge. Combining explicit and tacit learning can be challenging, as universities and the hospital trusts offering clinical placements are generally separate. Midwifery education follows two main tracks, with equivalent time spent in university and in clinical practice, consisting of community and hospital placements (NMC, 2009; 2019). Practice placements often have a strong professional culture (Divall, 2015) which have the potential to influence and shape the attitudes and behaviours of students (Willis, 1977, Henderson, Forrester et al., 2006).

It could be suggested, then, that this shared education may influence student midwives' understanding and learning about compassion. Therefore, exploring students' experiences of compassion during practice placements as well as throughout the university based parts of their education, seems important in investigating this issue in depth. Midwifery education is now briefly contextualised to set the scene.

1.2 A potted history of midwifery education

Midwifery education has evolved and developed over a number of decades. The English National Board for Nursing, Midwifery and Health Visiting (ENB) introduced the first three year pre-registration diploma and midwifery degree in 1989 (Fraser, 1998, p.1). The three year diploma and degree courses were implemented across the United Kingdom (U.K.) alongside a 78 week shortened course for registered nurses wishing to qualify as midwives (Fraser, 1998 p.13). The midwifery degree was not widely accessible or mandatory in the past with only a few providers offering this option (Fraser, 1998).

Most students currently enter midwifery directly. Very few student midwives hold a nursing qualification now, which was a requirement until 1989 (Fraser, 1998). There are also now very few universities that offer the eighteen month nurse to midwife conversion courses. In the early nineties midwifery education transferred into colleges and by 1995, into universities. Other changes included the certificate qualification being replaced by a diploma and this signalled midwifery advancing towards an academic profession status (Fraser, 1998).

This was a very different style of educating midwives from the previous apprenticeship style of training (Fraser, 1998).

Midwifery education has remained largely unchanged since the mid-nineties until 2019 when a few education providers in partnership with hospital trusts started to offer midwifery Apprenticeships (Council of Deans, 2020).
Since 2008 the NMC have stipulated that undergraduate midwifery education courses are offered at degree level, meaning that, compared with other professions such as teaching, midwifery is a relatively recent all graduate profession (NMC, 2009).

For qualification and entry to the NMC Register students need to demonstrate competence in the following five domains: '*being an accountable and autonomous midwife; the midwife's ability to provide and promote continuity of care and carer; universal care for all women and newborn infants and families; additional care for women, newborn infants and families with complications and/or further care needs; promoting safe and effective care: the midwife as a colleague, scholar and leader*'.(NMC, 2019 p. 1). Throughout the NMC's (2019) Standards of proficiency for midwives, the word compassion appears twice and compassionate features six times, further emphasising the importance of educating about and for the value in midwifery education.
Although midwifery curricula should intend to educate students about the previously mentioned domains; it is for the individual universities to decide how they teach and assess the standards. This flexibility may prevent a standardised approach to educating student midwives about and for compassion.

There are, however commonalities amongst education providers, including that for qualification and registration with the NMC students must pass both theory and practice (NMC, 2009; 2019).

Competency-based education (CBE) is the NMCs preferred method of educating student midwives. The Department of Health in 1999 stated that a government priority was for student midwives to be suitable for practice at the point of registration. This led to an increase in the practical skills within midwifery education and CBE was implemented into midwifery courses (DH, 1999). The CBE is an education based upon set outcomes (Mukhopadhyay and Smith, 2010). Researchers describe CBE as a problem-based concept, which resonates with midwifery education, as students are expected to manage clinical situations and solve complications if and when they arise (Savery, [2006], Polyzois, Claffey et al., [2010], Mkony, O'Sullivan et al., [2012]). Furthermore, CBE requires students to apply their knowledge of theory to the clinical experience and NMC (2009) competencies. The NMC (2009) state that competency is the ability to practise safely and competently without the need for supervision. However, the CBE approach is not without criticism. Lum (2013) warns that when work-related expertise is broken down into single tasks, such reductionism fails to recognise an individual's capability as a whole. Also, where there is a focus upon tasks and competence, this may be at the expense of the softer, human skills (Burnard, 2002) including compassion. Locally, therefore, a module educating students about compassion has sought to address criticisms that teaching the softer skills are being lost in CBE.

As a midwifery educator working in the Division of Midwifery at an East Midland's university, teaching and learning about compassion is of great personal interest to me. In 2015 the requirement to revalidate the existing pre-registration midwifery curriculum offered an opportunity to develop a Values Based Curriculum and underpin it with The 'Six Cs' (DH, 2012). The Values Based Curriculum was designed, developed and implemented. The curriculum included a new module called 'The Compassionate Midwife' and I was responsible for the design, development, implementation, assessment strategy and finally evaluating this module (1.3,. p.21).

The module was in the first taught theory block and prior to students' initial practice placement. This presented a unique research opportunity to learn more about teaching compassion to the new student midwives as well as gathering data from students who had already been taught about compassion and who had experienced varying lengths of time in practice. Coinciding with the development of this, I started a Professional Doctorate in Education which supported me in developing the research skills necessary to conduct this study. Thomson and Walker (2010, p. 21) argue that professional doctorates provide opportunities for producing *'good work'* and making potentially new and original contributions to knowledge about the problems that have evoked the practitioner's professional interests and institutional concerns (Thomson and Walker, 2010, p. 21). Exploring student midwives' learning about compassion resonated with my professional interest and the wider concerns I had about how we may educate students about this.

Before I became a midwifery educator, I worked for thirteen years as a clinical midwife based in an East Midlands hospital. Treating women and their families with compassion and delivering compassionate care has always been very important to me.

In addition to my clinical role, I was a mentor supporting student midwives' learning and assessing their NMC (2009) competencies in clinical practice. Alongside my job as a midwife, I was also a National Vocational Qualification (NVQ) assessor, a role which required me to teach and assess Maternity Care Support Workers with the main focus of further developing and expanding their existing roles.

Supporting others' education so that they can achieve their career aspirations and potential became increasingly important to me and I found it hugely rewarding. As a result of this in 2008 I applied for a secondment to the Division of Midwifery as a Lecturer Practitioner at my present university to pursue my passion for education. The post was extended for several years from the initial one year of secondment, until, finally, I was successful in securing a permanent job as a Teaching Associate in 2013, and subsequently I was promoted into my current role of Midwifery Assistant Professor in 2016.

My own experiences over the past 20 years as student, registered midwife, mentor and university educator have greatly influenced my current interest in the development of students' learning about compassion and in being compassionate towards women, their babies and families.

My motivation and interest in the research arose from my belief as an educator that the care women access in midwifery is greatly influenced by the theory and practice the midwives have learned during their education and clinical experiences. My position is that the ideas associated with the development of compassion can be both taught and learned. A brief outline of the content and assessment that the current compassion module comprises of follows, together with additional background detail in Appendix One (p. 238)

1.3 An outline of the compassion module

A dedicated module on compassion was being formally taught for the first time. A literature review identified the broad content of the module: ideas associated with, and relevant to, teaching compassion are detailed in Appendix one (p.238). The module was taught via a blended learning approach, described by Garrison and Kanuka (2004) as the amalgamation of instructed online learning followed by traditional face-to-face teaching lectures and workshops. Higher education has been charged with finding effective, flexible and alternative solutions to reduce teaching on-campus (Garrison and Kanuka, 2004).

Learning from this module was assessed by a written essay. Assessments can and do take many forms in midwifery education including essays, examinations, debates and clinical exams. Different assessment methods require different skills to be demonstrated (Race, 2014). For example the essay assessed students' written communication skills, insofar, as it covered the learning outcomes. This is a key tenet of any assessment as suggested by Race (2014). The essay questions to test the learning were developed and took account of what Hift (2014, p.1) describes as *a 'constructed- response'* question. These were

intended to test the students' higher order cognitive processes (Hift, 2014). Constructed- response questions required explanations of the reasoning behind answers and were considered a good fit for the module.

The command words for the question were taken from Bloom's Taxonomy of Learning (Anderson and Krathwohl, 2001) and were aimed at a first year undergraduate level of study. The pass mark for the assessment was 40%. Failing to achieve a pass mark did not necessarily mean that students undertaking this assessment were not compassionate. It is more likely that they were unable to articulate their ideas according to the accepted academic conventions. Likewise, students who passed the assessment were not necessarily compassionate. It perhaps showed that they understood the key ideas and were able to answer the essay question.

1.4 Thesis structure

Six chapters make-up this thesis with supporting references and appendices. This introductory chapter has set out why this research is needed and why now.

The literature review chapter explores the origins of compassion definitions and considers the cognate literatures of nursing and medicine. Wenger's (1998) Communities of Practice Social Learning Theory is briefly introduced in this chapter.

Chapter three discusses the research methodology and the philosophical foundation of my data collection methods and analysis. I reflect upon my personal and reflexive position during the study. I justify using a mixed methods methodology.

Chapter four presents the empirical data that has been generated including the findings and results of the study.

Chapter five discusses, evaluates and synthesises what the findings means for the teaching and learning about compassion in midwifery education. Wenger's (1998) Social Learning Theory and the Concept of learning within a Community of Practice provides a useful lens to view, assist the discussion and evaluation of the research findings and results in this chapter.

Finally chapter six summarises the study by describing the conclusions and implications for midwifery education and practice. The strengths and limitations of the study and its claims as an original contribution to knowledge are also discussed at this point.

Chapter two

2.1 Literature Review

The initial literature review for the study was carried out prior to the data collection, this aimed to identify existing research on the topic area. Reviewing the literatures was ongoing throughout the period of research activity. The standard method of searching for literatures on electronic databases and using key words, inclusion and exclusion criteria were employed. Hand-searching the located studies', reference lists, revealed additional research for review. The identified studies had been carried out in the United Kingdom (U.K.) perhaps due to the renewed focus of compassion as set out in chapter one and since publication of the Francis Report (2013).

The literature review revealed four main domains for consideration and these frame this chapter. Firstly, the philosophical and religious debates about whether compassion is innate or learned were key aspects emerging during the literature review. Secondly, the definitions of compassion and its relationship to other related constructs are discussed. Thirdly, compassion in healthcare literatures are explored and debated. The interventions thought useful in educating about and for compassion in healthcare are debated and reveal that this is an under-researched issue in midwifery education. Finally, what is known about how education for compassion may be enacted?

2.2 Philosophical and religious perspectives on compassion

Amongst the ancient philosophers, Protagoras and Socrates debated whether virtues were innate or learned (Deveterre, 2002). Protagoras argued that virtues can be learned and this is the stance of the researcher who has a firm

belief that the ideas associated with compassion can be both taught and learned. Socrates, contrary to Protagoras's view, asserted that virtues cannot be learned or taught as humans will always seek '*pleasure at any cost'*, and given a choice between rational or irrational choices humans will always choose the irrational (Deveterre, 2002 p. 20). This view seems difficult to sustain when considering that some humans do put others before themselves, for example members of some emergency services, who very often risk their own lives to serve others.

In contemporary healthcare, compassion is now mostly referred to as a value (Department of Health [DH], 2012) rather than a virtue as in the ancient philosophical writings. This is an interesting shift and so the two terms are worthy of consideration. There are clear differences between a person's virtue and their values. Virtues are thought to be the characteristics of a person, which might support their moral excellence. In comparison, Values can be described as the individual's accepted and cultural norms (Buetow, 2016). Those who ascribe to the idea of compassion as a value, rather than an innate virtue, are probably more likely to suggest that compassion is influenced by a person's early foundations including their parenting, schooling and religion, and to take the view that compassion can be taught, enhanced and is perhaps socially constructed (Pence, 1983). However, virtues can also be refined and enhanced through study and through social conditioning.

The quality of compassion is of significance in the major world religions: Christianity, Buddhism, Judaism and Islam (Armstrong, 2006).

Most religious traditions have a strong commitment to compassion as the means of developing a spiritual focus in enhancing social relationships and happiness (Gilbert, 2009). In all of the major religions compassion is thought an important requisite for religious followers during their lifelong journey. Compassion is highly regarded because it supports an individual's ability to try to alleviate another person's suffering or pain (Schantz, 2007). Compassion according to Buddhists involves sharing in another's grief or suffering (White, 1999, p. 115). Although Feldman and Kuyken, (2011) point out that compassion cannot alleviate physical and psychological suffering, the pain is perhaps easier to face when compassion is shown to an individual.

The major religions have different nuances in their perspective on compassion. In the Christian religion one's own behaviour should include reaching out to others (Cornelius, 2013). A key reference in the Bible, Luke 10:25–37 'teaches and exhorts' Christians to be compassionate through the story of the 'Good Samaritan'. In this well-known parable a traveller is stripped of his clothes, beaten and left for dead alongside a road; first a priest and then a Levite come across him, but do nothing to help. Finally, a Samaritan sees the injured man, bandages his wounds and takes care of him. The telling of this tale demonstrates the importance of compassion as a Christian value (Cornelius, 2013).

In the Islamic faith, the word 'compassion' is rah.ma and this offers '*representations of a central divine attribute*' (Svensson, 2013, p. 97). Compassion is mentioned in all but one chapter of the Qur'an. Compassion is a key Islamic requisite, frequently mentioned in daily speech amongst Muslims (Positive Muslims, 2004, p. 4). The importance of compassion in the Jewish faith is explained in the Tanakh, which states that those observing the Jewish religion are: '*rachmanin b'nai, achmanim*, *compassionate ones and the children of*

compassionate ones' (Dresner, 1954, p 35). This suggests that compassion is also central to Judaism.

In the Christian, Buddhist and Jewish faiths compassion is described as 'agape' and includes 'loving the other, avoiding being judgemental, accepting and valuing the other' (Montemaggi, 2018 p 642). Agape is described as the highest and purest form of the unselfish love for other human beings with the belief that strangers care for others as if they were family (Petruzello, 2019). It is useful to acknowledge that love has several meanings and that agape should not be confused with Eros, which means erotic love and this is a different quality involving physical satisfaction, which is often sexual (Petruzello, 2019). Therefore agape may be useful to consider alongside compassion in healthcare. Stickley and Freshwater (2002) point out that it is not unusual for nurses to experience feelings of love for their patients.

The relationship between compassion and religion is complex. On the one hand, the major faiths have a propensity towards recommending compassion to their followers. On the other hand, religions may set boundaries on the extent of compassion, which may not extend beyond the margins of their own faith communities. It may be that sometimes individuals are compassionate *'in spite of religion and not because of it'* (Brooks, 2004, p. 58).

Gilbert (2009) taking an evolutionary view, considers that compassion is reproductively advantageous. Compassionate communities that nurture and protect their young may be more successful, when, rearing their offspring (Gilbert, 2009). Gilbert lists a range of behaviours and attributes related to being compassionate needed to rear the young: '*behaviour that aims to nurture, look after, teach, guide, mentor, soothe, protect, offer*

feelings of acceptance and belonging-in order to benefit another person' (Gilbert, 2009, p. 217). Gilbert's (2009) work centres on disorders of the mind, which perhaps shaped this definition of compassion. Gilbert's interpretation of compassion considers how it is enacted with patients who have emotional, mental and behavioural difficulties. People with such psychological disorders may be considered vulnerable and compassion in this context suggests the need for nurturing by those who care for them. Furthermore Gilbert, 2009 describes Acceptance Commitment Therapy (ACT) as a key process in clinical psychology therapy suggesting that difficulties often occur when individuals avoid painful feelings and it is their acceptance of self that is key to their recovery process. Such profession-specific nuances inform definitions of compassion and its professional contexts (Gilbert, 2009). This definition seems to align well to how compassion may be shown in the field of clinical psychology, though it does not have resonance with midwifery and healthcare per se. Therefore definitions that might more closely describe compassion in a healthcare context are explored next.

2.3 Defining compassion

The word compassion has been in use since at least the fourteenth century and the etymology of the word emerges from the Latin, *com* which means together 'with' and *pati*, which is suffer: in other words to '*suffer with'*, (Thompson, 1995, p. 270). Suffering may be a term that has a different meaning according to someone's culture, background and value-beliefs (Saunders, 2015); this adds to the lack of universality in defining compassion. Thompson (1995, p. 1392) suggests that suffer means to, '*undergo, grief, pain or damage' and is noted to be threefold: '...physical, emotional and spiritual'* (Schulz, 2007, p. 5). Those accessing healthcare may be affected by one or all of these aspects of suffering.

Compassion is said to: '*help the burden of suffering to be more bearable...and is a healing force*' (Frost, Dutton et al., 2006, p. 843).

Recognising patients' suffering, may support healthcare professionals to be compassionate. Furthermore, this requires an understanding and facilitating of the healthcare professionals individual emotions. In turn this will assist a better understanding of their relationships with others and arguably recognise when patients are suffering. Understanding one's own emotions as being central to relationships with others, was first described by Salovey and Mayer in 1990 as Emotional Intelligence (EI). Therefore, if midwives are to understand better the suffering of those in their care, knowledge of the importance of EI as a personal and a professional attribute is an essential aspect in being compassionate.

A full definition of compassion perhaps includes considerations other than just the alleviation of suffering. In this respect, there are few midwifery- specific definitions found during the literature search. One is from Hall (2013): '*compassion is a concept that implies the other is of worth, a depth of care that goes beyond a professional relationship'* (Hall, 2013, p. 269). Hall's definition is interesting as it suggests that compassion requires midwives to value women and consider that they are worthy of compassion; furthermore that the care given needs to extend beyond a professional relationship and could perhaps include friendship. The position of the midwife as both a professional and a friend to women was first suggested in 1999 by Walsh. In Walsh's ethnographic study of women's experiences of the relationship with their midwives, the most common adjective used by the women was the word 'friendship'. This led to Walsh's suggestion that midwives could be a *'professional as a friend'* (Walsh, 1999, p. 165). Compassion here takes on a different

perspective than just the alleviation of suffering, as it would seem that the midwife and mother relationship is an important aspect during care delivery.

A working definition of compassion and one that needs to be observed by both midwives and nurses, was set out in 2012 by the Department of Health. It is known as the Compassion in Practice vision. It defines compassion in the following manner: *'compassion is how care is given through relationships based on empathy, respect and dignity-it can also be described as intelligent kindness, and is central to how people perceive their care'* (DH, 2012, p. 28).

This definition notably does not include the idea of suffering. The term *relationships* in the DH (2012) definition resonates with the association that midwives engage in with women and their families. Both respect and dignity are the minimum expected professional standards for everyone that a midwife cares for (NMC, 2015, 2018). Within the DH definition, *intelligent kindness,* first cited by Ballatt and Campling (2011), expresses the positive values that should define healthcare and not the negativity which has often been associated with care in recent years (Francis, 2013; DH, 2012; Kirkup, 2015). The concept of intelligent kindness is rooted in a sophisticated view of knowing and kindness, a notion which arises from the early etymological origins of the word 'kind', described by Campling (2015), 'as kin'; in other words to treat others as a family member.
This suggests that kindness may be a natural phenomenon, a view supported by Thompson's (1995, p. 747) definition that sets out: *'kindness is to act according to the laws of nature'.* Unfortunately, the many atrocities and crimes in the world make it clear that not all human beings are predisposed to being kind.

Kindness, altruism and compassion are terms associated with one another and often used together, however whilst they have similarities there are also distinctive differences worthy of note. Altruism is described by Baston, (2002, p. 90) as a: '*motivation to benefit others'*. Some have suggested that altruism is helping another without wishing this to be reciprocal or receiving a reward (Monroe, 2002). The overlap between altruism and compassion is that each requires a connection with the other, and any concern for others should be greater than for ourselves. Here then, a tension arises if the true interpretation of the term is applied, given that midwives are paid to provide care; it perhaps could be argued they are not doing so altruistically.

Youngson's definition acknowledges that compassion is complicated to define: *'compassion is a complex construct including elements of empathy, sympathy, sensitivity, non-judgement, tolerance of distress and motivation'* (2015, p. 67). Words such as pity and sympathy are often used synonymously and mistakenly for compassion, which adds to the complexity of defining it. Pity and sympathy are a combination of beliefs and feelings (Snow, 1991, p. 196). For example, pity involves keeping a safe emotional distance from the person who is suffering and is in contrast to compassion which, involves '*crossing the emotional distance'*, to become more involved and closer to the sufferer (Snow, 1991 p. 197). This is further echoed by Walker, Quinn et al., (2016) who propose that a feeling of connection to the sufferer is vital when being compassionate.

Sympathy is also often associated with compassion and used in response to a multitude of adversities, such as a non-tragic event like the loss of a material possession (Snow, 1991). Therefore, sympathy is identified as an emotion that is less intense than

compassion. It would seem that the more profoundly we are moved by the other's plight the likelihood of compassion being initiated (Saunders, 2015).

According to Strauss, Taylor et al., (2016), compassion requires five sequential steps: '*recognising suffering; understanding the universality of human suffering; feeling for the person suffering; tolerating uncomfortable feelings, and motivation to act/acting to alleviate suffering'* (Strauss, et al., 2016 p. 15). Here it seems that key to compassion being shown is to recognise suffering; however, as discussed previously, compassion has come to mean more than just to alleviate suffering.

Taylor, Hodgson et al., (2017) also point out that there are five steps necessary for putting compassion into action. These are: '*recognition; connection; altruistic desire; humanistic response and action'* (Taylor et al., 2017, p.350). Further to this, recognition of distress was considered by Taylor et al., (2017) as an antecedent of suffering and, associated with this illness, loss, and grief were amongst the terms described as useful in recognising suffering. Connecting with an individual was considered to rely on closeness by the healthcare professional through being in attendance and showing attentiveness. Taylor et al., (2017) also suggested that altruistic desire may be shaped by personal experience, thus indicating that compassion could be a learned attribute. Furthermore, that compassion involves a humanistic response, which in turn requires advanced communication skills and finally action through the capability of the healthcare professional (Taylor et al., 2017). Capability is an interesting term as it is often used interchangeably with the word competence in midwifery education to describe whether a student can undertake clinical skills efficiently or not (NMC, 2019). Capability suggests that compassion perhaps can be learned.

Kanov, Powley et al., (2017) and Dutton, Workman et al., (2014), suggest that compassion requires four steps: noticing the other's suffering; feeling an empathic concern; making sense of the situation and finally taking action. It seems a reasonable assumption insofar as helping to alleviate suffering requires that it firstly has to be recognised. However, if compassion can only be shown in the presence of suffering as Kanov et al., (2017) and Dutton et al., (2014) suggest, this may be problematic for individuals who are not outwardly showing signs of suffering. Therefore, it could be proposed that being compassionate should be the default position of all healthcare professionals whether an individual is perceived to be suffering or not. Kanov et al., (2017) and Dutton et al., (2014), suggest that healthcare professionals need to be able to show empathy and that this is often used interchangeably and synonymously with compassion. However, there are differences, as described by Noddings (2003), as empathy includes putting yourself in the other's shoes. Whilst healthcare professionals are expected to be empathic they may also need to remain detached from those in their care to avoid their personal values interfering with their relationships (von Dietze and Orb, 2000). This presents a tension if we regard compassion as requiring the deliberate participation in another's suffering (von Dietze and Orb, 2000).

The third step toward compassion considered by Kanov et al., (2017) and Dutton et al., (2014) is to '*make sense of the situation'*. To fulfil this in midwifery strong and meaningful relationships with women are encouraged. The term midwife means 'with woman' and it is absolutely necessary for the unique relationship that should develop during a woman's pregnancy and birth. This also requires that the midwife should be positioned alongside the woman (Bradfield, Duggan et al., 2018). The final step toward compassion according to Kanov et al., (2017) and Dutton et al., (2014), is '*taking action'*.

For Fox (1990) the action toward, compassion requires togetherness and even celebration. Compassion and 'taking action' for Nouwen, McNeill et al., (1982) are not exclusively to alleviate suffering, instead they are more about solidarity with the sufferer and a willingness to share their problems. Nouwen et al., (1982, p. 4) define this as: *'compassion expects us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable and powerless with the powerless. Compassion means full immersion into the condition of being human.'*

2.4 Compassion in healthcare

The origins of compassion in healthcare can be traced back to Florence Nightingale who is mostly associated with nurses as both professional and good individuals who cultivated particular morals and virtues within their character (Bradshaw, 2011). During Nightingale's tenure, 1873-1897, and until the 1960s, most nursing text books included a narrative that nurses should develop both a virtuous and moral character to become compassionate (Bradshaw, 2011). Underpinning this sentiment was the view that compassion could be developed and learned.

After the 1960s, compassion mostly did not feature in the nursing texts or in its theories. The reason for this is not clear from the nursing literatures (Crawford, Brown et al., 2014; Reed, Shearer et al., 2004; Kim and Kollak 2006; Bradshaw, 2011). Armstrong's (2006) view is that in the past learning about compassion has been overlooked because of a focus on the: institutional; political and intellectual developments. This same trend has unfortunately been evident in contemporary healthcare (Francis, 2013).

After the 1960s a biomedical model of nursing emerged and with it a more contemporary age, including an incremental emphasis upon academic achievement (Bradshaw, 2011). The medical profession is also considered by some scholars not to have the emphasis upon compassion that it perhaps should (Geary, McKee et al., 2014). On the one hand in the medical profession compassion means that doctors are expected to alleviate and where possible cure human suffering, and therefore the literal meaning of compassion can be seen to have resonance with medicine (Haq, 2014, p. 549). However, on the other hand there is little emphasis upon compassion in medical school curricula and instead the focus according to some is upon: '*data acquisition and subsequent regurgitation, test performance, and competition*' (Geary, et al., 2014 p. 203). Perhaps, when they start their education medical students have the desire to care for and be of service to others. However, whilst their Medical Schools will emphasise humanistic skills unfortunately the curriculum simply does not foster compassion. Some have described this as a degeneration of the value (Dobie, 2007, Shapiro, 2011). Reasons for this decline are suggested as: '*poor faculty role-models, medical technology, short office and hospital visits, and the lack of long-term relationships with patients'* (Geary et al., 2014 p. 203). Recently, then, it could be argued that due to the failings in healthcare, medicine has, like other healthcare professions, needed to re-evaluate compassion as an important element of a doctor's role. Medical education has been called upon to place more emphasis upon the teaching of personal qualities that exist in the doctor-patient relationship. It is therefore surprising that there is such a paucity of literature about how medical students are taught and learn the concepts associated with compassion. A joint statement on the 31st August 2012 from the General Medical Council (GMC) and the NMC proposed a unified approach from medicine, midwifery and nursing, arguing that: '*health professionals need to demonstrate compassion and kindness, as well as knowledge and skills'*.

These sentiments were also the view of Pence (1983, p. 189) over three decades ago. Pence asked: '*can compassion be taught, supressed or indeed developed in medical Students*?' Pence suggested that medical educators who think that compassion is learned through 'osmosis' by being around suffering patients and that formal teaching is not required is not the case (Pence, 1983, p. 190). It has been shown that compassionate behaviour is not always shown to those who are suffering (Francis, 2013) and where doctors are not demonstrating compassion it may indicate to medical students that this is acceptable during care delivery.

Other views are that the absence of compassion shown by doctors as mentors may well actually inspire compassion, as medical students consider this is the kind of doctor they themselves do not want to become (Pence, 1983). In this view, the absence of compassion is rendered as useful in some students' learning. Additionally, simply imitating compassion is not being compassionate as there are more profound internal attitudes and emotions that render compassion as complex (Pence, 1983). The clinical placement may also be a barrier to compassion with pressures on time and a high volume of patients requiring care, rather than a focus on individuals who might influence a medical student's learning about the ideas associated with compassion (Pence, 1983, Saunders, 2015). This suggests the need for compassion to be taught in medical students' curricula, according to Saunders (2015). Furthermore, consideration of how compassionate behaviours are rewarded amongst medical students may help to support its importance, together with allowing time to be spent with individual patients and the acknowledgment by educators that compassion is indeed a worthy quality and one that should be encouraged (Pence, 1983). Others argue that, to be compassionate, medical students need '*repeated practice'* (Geary et al., 2014, p. 203); this could be considered a useful intervention.

A specific midwifery study focusing upon compassion located during the literature review was the work of Menage (2018). This study researched women's' perspectives about midwifery care with a focus upon compassion. It offers an important consideration for educating student midwives about and for compassion during their education. Menage's (2018), study aimed to contribute to an understanding of what compassionate midwifery means to women accessing the maternity services. This study has resonance for me as it is important for midwifery education to consider what women think about compassion and compassionate care. Menage's findings reveal women's lived experiences of receiving compassion from midwives. A qualitative interpretive phenomenological analysis methodology was utilised to establish the perspectives of seventeen women. The data revealed six emerging themes, which were: *women's need for compassion; being with me; relationship; empowerment; balance and finally compassion all made a difference* (Menage, 2018, p. ii). Women considered compassionate midwifery to involve a number of different features including midwives being calm, relaxed and communicating through information giving, which, in turn, supported women to feel empowered in their decision making.

Furthermore, women wanted their midwife to be available and it may be surmised that this included continuity of carer. The development of relationships and the midwife seeming like a *'friend or family'* member was also valued by the women (Menage, 2018 p 175). These are valuable findings and ones that are useful to keep in focus, when educating student midwives about being compassionate carers.

A number of researchers have set out to better understand what might be useful when educating healthcare professionals about compassion. These researchers are predominantly in nursing with a few in medicine. The research discussed in the next

section is not specific to midwifery, as it is mainly about nursing and medicine. These two professions closely align to and often work inter-professionally with midwifery. Therefore, the following literatures are considered useful, in the absence of midwifery specific research, to better understand the ideas and interventions for teaching future student midwives about compassion.

2.5 Education about compassion in nursing and medicine

Curtis, (2013) collected data via single in-depth interviews with five male and female nurse teachers to elicit perspectives about compassion during students' education. The findings suggested the difficulties in providing the individual or small group work needed to ensure students' comprehension of compassion and to offer the emotional support needed for the large student nurse cohort numbers in pre-registration education. Curtis found that learning allocated to lecture theatres with large numbers of students did not support meaningful dialogues about compassion. The study highlighted that teaching about compassion was more optimal in smaller sub- groups of a cohort and that further research is needed. This research adds to the body of knowledge; however learning about compassion does not exclusively take place in the university and research considering practice would also be useful. Midwifery and nursing students spend approximately 50% of their respective courses in practice and so this is a key consideration for learning about compassion.

In considering learning about compassion in both theory and practice, Walker et al., (2016, p. 23) acknowledges that the value is multifaceted, including both thinking and feeling that can be simultaneously, '*conscious and unconscious'*. This is compounded by a preponderance of conditions and morals that, when combined with '*nursing standards and expectations*', can be difficult for student nurses (Walker et al., 2016, p. 23). To overcome

this and key to the development of compassion in students, Walker therefore suggests that reflection skills and self-awareness should be nurtured in undergraduate nursing curricula.

Adam and Taylor's (2014) study attempted to see how theory and practice align to support student nurses' learning about and for compassion. Thirty seven student nurses' written reflective patient care accounts were explored with personal tutors in small groups of a larger cohort. The aim of the teaching intervention was to elicit gaps in the students' knowledge and identify the skills associated with giving compassionate care. It was not clear what the identified gaps were and so considered a limitation of the study.

Future teaching was developed for the theory sessions. This focused upon deficits in the students' knowledge and skills about compassion, as elicited from their written reflections. This seemingly bridges the gap between the university and practice settings. In turn, when students use their experiences from both settings it perhaps supports learning holistically about compassion doing what Lave and Wenger (1991, p. 21) describe as developing '*portable interactive skills'*. As nurse teachers tend not to work clinically with students in the practice setting, reflection upon the student's interfaces with patients were found useful for learning about compassion (Adam and Taylor, 2014). The students' summative assessments from the teaching intervention revealed that the student nurses' understanding of compassionate care had improved, suggesting that reflection upon clinical experiences can support students' development of compassion.

Adam and Taylor's (2014) study echoes Adamson and Dewar's (2015) action research, *Leadership in Compassionate Care Programme*. The three year action research project sought to capture what compassionate care means in nursing practice by gathering stories

from nurses, patients and families in hospital. The sample of 37 student nurses were enrolled on a module that had developed the stories to assist teaching them about compassion. Evaluation found that compassionate care can be developed through introducing this kind of intervention - stories about interactions with patients that evoke emotions in students - into a nursing curriculum.

Attempting to show the relationship between the role of education and students' development of compassion, Bray, O'Brien et al., (2014), used a mixed methods methodology collecting data that included surveys and qualitative semi-structured interviews. The findings claimed to show that 197 pre-registration students and 155 qualified health professionals and in a United Kingdom (U.K.) university had a good understanding of what compassion means in healthcare (Bray et al., 2014). Recommendations of the study were that better understanding of education's role in fostering compassionate behaviours was needed. Geraghty, Lauva et al., (2016) agreed with Bray, et al., (2014) findings and stated that current curricula should include the signs and symptoms of uncompassionate behaviours amongst students' mentors; that this should take place each year of the education programme and be made mandatory.

The meaning of compassion amongst undergraduate student nurses, both in their education and practice, was explored by Jack and Tetley (2016). The study drew upon the students' reflective poems and utilised an interpretative phenomenological approach. An entire cohort of 42 Bachelor of Science nursing students were invited to write poems related to their experiences of compassion. Twenty four poems were submitted. The study findings indicated that compassion may be difficult for students to deal with in practice as

caring for others can leave students feeling vulnerable and inadequate (Jack and Tetley, 2016). The use of poetry can offer educators insight into how students are feeling about compassion and in turn this may assist with the future education of the value. Whilst the research does offer insight into student nurses' experiences of compassion through the use of creative writing it is a relatively novel way to explore it. More research is needed to establish its pedagogical value for learning. Poetry may be useful for student midwives to express their experiences of compassion, however, evaluation of student learning together with any associated changes made to the student's approach to compassionate practice would need to be considered. This appeared to be omitted from Jack and Tetley's (2016) study.

Hofmeyer, Toffoli et al., (2018) explored the online learning of compassion. The methodology was an exploratory and descriptive qualitative approach with data being collected from open-ended questionnaires administered pre and post studying the online module. The online self-directed module on compassion was an optional module undertaken during the Bachelor of Nursing's students' final year. The module took between four and six hours to complete. Of the 362 students invited to take part, only 54 students participated, which in itself is a revealing finding.

It could be speculated that third year students on a Bachelor of Nursing course perhaps were already at their capacity for workload and as this was optional, declined to take part. The study showed that nursing students can firstly 'learn about compassion and self-care practices to cultivate resilience. Resilience is considered by the DH (2016) to be an important aspect in ensuring the future healthcare workforce adapts well in the face of adversity. Both midwives and nurses face difficult and emotionally charged situations in their work and so resilience is considered both a personal

and professionally desirable attribute (DH, 2016). Resilience is explored further in (5.6.2, p.164-166). Secondly, the study showed that students can foster their ability to provide compassionate care for patients and promote the value in their teams' (Hofmeyer et al., 2018 p. 311). Whilst useful to explore online learning as an opportunity for increasing compassion, given its importance and renewed focus a module about the value arguably should be early on in a student's education, made mandatory and revisited annually throughout their education and beyond.

Other authors have also proposed practices useful to learning about compassion. Price's (2013, p. 53) theoretical paper suggested three useful aspects: '*working closely with patients and lay carers' experiences; re-examining how skilful nurses are and enhancing teaching in the clinical area'*. For this to be achieved nurses need to understand and discuss patients' individual circumstances. This communication may result in action to help sooner or perhaps differently. In this way, patients may perceive care to be more compassionate.

Developing skills that nurses consider work to promote compassion, can further enhance implementing the value with patients. Furthermore, it can assist in teaching compassion to students in the clinical area. This paper highlights the importance of education and clinical practice working together; during a healthcare student's education to support learning about compassion.

A discursive literature review on compassion in nursing revealed that patients were aware when nurses were compassionate during care delivery and that the value could and should be taught in nursing curricula. This shows the importance of research taking into account, nurse and patient perspectives to inform the ideas that are useful for fostering compassion (Richardson et al., 2015).

In a study by Curtis, Horton et al., (2012), student nurses were interviewed about their socialisation into clinical practice and the impact that this had upon learning about compassion (Curtis et al., 2012). These in-depth and digitally recorded interviews with 19 student nurses and five teachers helped to build a contextual picture of their experiences of socialisation into practice. It was concluded that professional socialisation into settings where compassion can develop is crucial for students' education. Whilst the limitations of a single study site and the number of participants were noted, this study suggests that compassion may be learned by students if they observe their mentor demonstrating the value. The study indicated that compassion may be learned in clinical practice through socialisation when the staff supporting students, themselves, foster the value.

Supporting Curtis's (2013) claim that the environment and the interactions with the people are useful for learning about compassion was Brown's 2013 Teaching and Learning Project. The project suggested that observing suffering through interactions supported student nurses' learning about compassion. Students spent time with homeless people in a day care shelter and helped them to connect with friends and family through social media. This allowed students to reflect upon the homeless people's suffering together with the daily challenges they faced. These experiences assisted student nurses in becoming more compassionate by raising their self-awareness. The student nurses taking part in the project reported that interactions with homeless people had been useful in two ways: firstly by helping them to be compassionate and secondly by making them more hopeful about giving compassionate care in the future. Considering this approach for student midwives learning, there is no flexibility within NMC approved curricula to include

placements in homeless shelters; however, it does highlight that placements and interactions with people are important for the development of compassion.

In professions such as midwifery and nursing where theory and practice are inextricably linked, considering both service users and nurses' perspectives on compassion are useful to contemplate how student learning can be further developed. The importance of compassionate care delivery in nursing for patients and families is well documented (Bramley and Matiti, 2014; Sinclair, Mc Clement et al., 2016), and the nursing literatures espouse compassion as equally important as clinical competence and a mark of high quality care that improves outcomes for patients. Compassion should be easy to recognise when it is either present or absent (Burnell and Agan, 2013).

Watson's 1996 seminal Theory of Transpersonal Caring has long been recognised as assisting in the direction, discipline and professional educational development of student nurses (Watson, 2008). Transpersonal caring is realised through the hierarchical Carative Factors that characterise human-to-human caring. These are: '*cultivating the practice of: lovingkindness and equanimity toward self and others as foundational to caritas consciousness; being authentically present; enabling, sustaining and honouring the faith; hope and the deep belief system and the inner-subjective life world'* (Watson, 2008 p. 39). This framework has been a useful and well referenced guide for nurse education, interestingly, however, the word compassion is notably absent. This maybe because, until recently, compassion and compassionate behaviours have not been questioned amongst healthcare professionals (Francis, 2013).

Emerging from this framework was a concept described as transpersonal teaching-learning: Watson (2008), suggested that health education should not just be didactic

information given to nursing students but instead it should be a situational exploration of practice learning. Watson's theory also tells us that learning within nursing when viewed only as a science is one dimensional and the world should also be viewed from imaginative and visual perspectives too. More recently Sandberg, (2016), sought to consider compassion learning alongside Watson's theories, suggesting that to learn effectively about the ideas associated with compassion means that the boundary of the classroom has to be extended. Educational approaches needed for developing compassion should include a shift from *'technical proficiency, nursing knowledge and evidenced based practice' to learning that connects the cognitive and affective domain'* (Sandberg, 2016, p. 166). Central to this notion is student engagement with patients during care interactions in placements as compassion can be difficult to teach and requires more than just the presentation of facts and techniques (Sandberg, 2016, p. 166). Following Sandberg's example, learning about compassion should move students beyond factual learning towards an understanding of patients' perspectives.

Affective learning requires activities that evoke an emotional response, which, in turn can result in a changed perspective. Learning in the university through formal teaching alone is not enough, and instead theory and practice need to work together. Theory about compassion may include educators sharing their experiences of care interactions with patients through storytelling, which also has the potential of evoking emotions in students. Also useful to help students' about and for compassion may be through the use of videos and the media; such images may portray illness and suffering that could not be expressed through the spoken word alone.

Research using grounded theory aimed to elicit the perspectives about compassion and compassionate care of older patients in long term care together with the nurses' opinions

of caring for them (van der Cingel, 2011). Findings showed that ccompassion relies upon intuition and communication, triggered by observing the patient's suffering. Furthermore, compassion is validated in seven steps: *practising attentiveness; active listening; confronting; involvements in care; helping; presence, and understanding patients' needs and sufferings* (van der Cingel, 2011 p. 676). Such research findings offer insight into how students' learning could be focused, however, specific consideration for midwifery is lacking. Whilst midwives need to be attentive to women and active listening is key when communicating, the term confronting as seen in van der Cingel's (2011) seven steps for compassion does not really fit with the Maternity Service's philosophy. Childbearing women are generally not confronted; for example if a women did not take the midwives' advice about her health, midwives have an unconditional duty to provide care. Therefore, the term confront does not necessarily align to midwifery showing that compassion may be context and profession specific, (and warranting this midwifery-centred research into educating about the value). Moreover van der Cingel's (2011) study highlights key differences between nursing and midwifery as some nurses provide long-term care spanning several years and in midwifery the care provided is mostly short term with pregnancy and childbirth in the main lasting nine months.

Further research about compassion by van der Cingel in 2014 reviewed patients' and nurses' perspectives on compassion. The study consisted of 61 in-depth interviews and six group interviews with patients and nurses. It concluded that compassion can be learned and it is not just an inherent personal characteristic. Acknowledgment that compassion should be taught in nursing curricula may suggest that it is not wholly learned during practice exposure. This supports the notion that learning about and for compassion in healthcare is a partnership between educators and those supporting students' learning in

the clinical placements. van der Cingel (2014) concluded that compassion education should include the nurturing of reflective skills, supporting student nurses to review their behaviour in clinical situations, learn from and share these experiences with educators and clinical supervisors. Reflection upon stories from clinical practice may assist students to further consider their emotions and thus facilitate exploration of values such as compassion (van der Cingel, 2014).

Compassionate care in nursing is not well defined. This is highlighted by Schantz's concept analysis in 2007 and later research by Burnell and Agan in 2013, who suggested that a standard measure of compassion was needed. Bradshaw (2009) opposes any measurement of compassion; Bradshaw doubting that the value can be measured and believes that to do so is inappropriate. Moreover, upon establishing a measure of compassion, Sturgeon (2010), doubts this would improve compassion in healthcare students or qualified staff. Compassion is a quality that needs nurturing, indicating that in Sturgeon's view, compassion can be learned.

Despite these views, a Compassionate Care Assessment Tool (CCAT) using a standardised scale was developed (Burnell and Agan 2013). Using survey method to collect the data, a sample of hospitalised patients, identification of demographic variables, and a factor analysis, the research organised and classified what constituted compassionate care. Additionally the CCAT identified the attributes needed for compassionate care, measuring these requisites and promoting their implementation in care delivery (Burnell and Agan, 2013). The CCAT was developed by combining two existing survey tools: The Spiritual Needs Survey (SNS) (Galek, Falnnelly et al., 2005), and the Caring Behaviours Inventory (CBI) (Wu, Larrabee et al., 2006). The resulting formulation of the CCAT tool concluded

that patients described four important key themes that to them signalled compassionate care: meaningful connection; patient expectations; caring attributes, and a capable practitioner. Whilst this research adds to the corpus of knowledge and noting that the researchers suggest that a further investigation in this area is required for the consistency and measurement of compassionate care delivery, it does not address the gap in knowledge for midwifery education.

Compassion perspectives from healthcare professionals were explored by Clift and Steele (2015). Two hundred and eighty frontline multi-faith and multi-cultural healthcare staff were asked two questions: what does compassion mean to you? And describe an example of where you have shown compassion (Clift and Steele, 2015, p. 21). Two hundred and eighteen out of 280 questionnaires were returned representing an excellent survey response rate (Cohen, Manion et al., 2011) and perhaps showing that healthcare professionals are wishing to advance the knowledge about compassion. Emerging themes were: communication, helping, caring, empathy, kindness, listening, sympathy and understanding. From this data it appears that compassion is a broad term that encapsulates a number of different requisites and is not just one act that healthcare professionals implement during care delivery. The alleviation of suffering associated with the term compassion is also noted to be absent from the emerging themes (Clift and Steele, 2015).

According with Clift and Steele, Bramley and Matiti (2014) suggest that whilst nurses are familiar with patients' suffering, this is not the only consideration of compassion; it is also necessary to understand the patients' experience and support them in keeping their independence and dignity. A purposive sample of ten patients participated in qualitative and exploratory descriptive research; data were collected through semi-structured

interviews (Bramley and Matiti, 2014). The aim of the study was to elicit how patients experience compassion through nursing care and subsequently using their perceptions to consider how to develop compassionate nurses. The findings suggested that patients expect compassion within nursing care and appreciated the smallest actions that were considered compassionate. Being given time by the nurse was crucial for patients, even if it was fleeting, to establish a compassionate connection (Bramley and Matiti, 2014). The results suggested that if nurses could see their own non-compassionate behaviour, this could help them to change and become more compassionate (Bramley and Matiti 2014). It is not clear from this study what the suggestions are for how this may be operationalised. However, suggestions for improving compassion amongst nurses by Walker et al,. (2016) attest that compassion must be taught in degree level pre-registration nurse curricula to ensure that nurses are aware of the concepts associated with the value.

Aiming to understand compassion perspectives from stakeholders, including health and social care students and staff, healthcare clinical staff and the public was the aim of a study by Kneafsey, Brown et al., (2016). The study adopted a qualitative methodology as a way of understanding the stakeholders' perceptions and interpretations of compassion. Nine focus groups conducted with 45 participants utilised a semi-structured interview method to collect the data. Four themes emerged: compassion: *'a big word that you can't summarise in one'; positive communication and consistency; losing compassion when the system takes over, and supporting compassionate practice'*. (Kneafsey, et al., 2016 p. 72). The theme relating to compassion as not just one aspect accords with the views of both Schantz (2007) and Youngson (2015). Communication associated with compassion and the barriers in healthcare systems that prevent staff being compassionate also

concurs with Clift and Steel's (2015) study. An important finding identified by the researchers is that compassion should be given by healthcare staff consistently and genuinely (Kneafsey et al., 2016). Burnell's (2009) analysis of compassionate care accords with these findings, concluding that compassion is not just a theory or nursing model it should be a genuine bond between a nurse and patient. Whilst it seems obvious that compassion should be authentic, the study highlights the important role that educators and education may have in preparing compassionate healthcare professionals of the future.

Phenomenological research aimed at exploring intensive care nurses' perspectives on compassionate care delivery amongst patients with long term respiratory problems noted three emerging themes: preparing to care for breathlessness; establishing a trusting relationship, and approach each person with as a person with unique needs (Kvangarsnes, Torheim et al., 2013). Whilst there is some resonance from this study for midwifery as women are treated as individuals aiming to develop a trusting relationship with midwives, the study also shows differences between professions, namely those that are related to long term illness which, generally is not a feature of midwifery care.

The above literatures have focused on learning about compassion both through the perspectives of patients and nurses, together with the interventions that are useful when educating for and about the value. A study by Horsburgh and Ross (2013) advocates that compassion must be a focus for qualified nurses, and that to ensure the success of compassionate care delivery this should be in the form of supportive frameworks during at least the first year of practice. This qualitative study used six separate focus groups and collected data from 42 participants; it concluded that the transition into becoming a

compassionate and qualified nurse is a little documented and often forgotten but crucial aspect of compassion.

Cultural differences in perspectives on compassion were explored using a cross-sectional descriptive study, the method was an international, online questionnaire. A total of 1323 nurses from 15 countries completed the survey (Papadopoulos, Zorba et al., 2016). This study explored whether nurses' definitions and experiences of compassion vary according to their country and culture. The results showed many similarities and differences between countries highlighting a need to better understand the influence of culture on nurses' perceptions of compassion. This is especially important as the NHS is a multicultural and ethnically diverse healthcare environment (Papadopoulos et al., 2016). Findings suggest that compassion is not adequately addressed in education or supported in practice by managers. This highlights the point that a renewed understanding of educating undergraduate healthcare students about compassion is needed. It also suggests that educators need to know the practice environments that their students are exposed to and learn within.

Drawing together 29 literature sources in 2019, Younas and Maddigan's critical review aimed to develop strategic policy direction to foster compassion in future nursing students and develop the pre-registration nursing curricula (Younas and Maddigan, 2019). Three directions for the future nursing curriculum were established: nursing curricula should allocate teaching-learning strategies that target affective domain learning; utilise reflection including reflective thinking in students to develop excellence in clinical practice, and incorporate information that can be assessed to elicit students' understanding and expression throughout the nursing curriculum (Younas and Maddigan, 2019 p. 1621). All

of the 29 sources reviewed were nursing focused, further illuminating that midwifery perspectives are largely absent from educational literatures about compassion.

There is a paucity of literatures relating to compassion education in medicine. In considering where and from whom compassion has been taught to medical students, one hundred and twelve fourth year medical students were asked to write an essay about how their medical education had nurtured or skewed their impressions of compassion (Wear and Zarconi, 2007). Fifty two (46%) students consented to their essays being used in the study. An inductive qualitative approach was used to uncover the emerging themes.

Three themes emerged: foundational influences such as parenting, and religious faith; preclinical educational influences including formal classroom experiences and clinical education influences with an emphasis on positive role-models. Concurring with Aristotle, foundational influences suggested that some parents deliberately instil compassionate ideals in their children. There are some issues to consider with this assumption, for example, not all students have foundational influences, for example, in the case of looked after children. Preclinical Educational Influences such as the mainstream schooling and subsequent education in the medical school suggested that the academic environment and culture in medical school was the antithesis of compassion, given that so much emphasis was placed upon succeeding and being the best (Wear and Zarconi, 2007). Additionally, the study participants cautioned that in cultures of competiveness, actions of compassion and kindness were not acknowledged and these attributes were deemed meaningless.

Participants proposed that they had observed mentors who were kind, altruistic and compassionate to patients, however, there were also those who were not compassionate to patients; subsequently this added to the medical student's vision of the doctor that they

did not want to become (Wear and Zarconi, 2007). This leads to thinking, then, that compassion may be learned through the presence and absence of compassion in those that students observed in clinical practice.

The University of Texas Medical Branch, [UTMB] attempted to address the compassion deficit and introduced an innovation called The Physician Healer Track (PHT), for a small number of medical students (Geary et al., 2014). It was intended to help medical students maintain their: '*innate compassion and humanity'* and to develop what are considered personal skills in relation to clinical care (Geary et al., 2014 p. 203).
Medical students were offered an optional six months education, which, focused upon: '*self-awareness, self-reflection, interpersonal communication skills, self-care, and work-life balance'* (Geary et al., 2014 p. 203). This optional education was offered to 10 students and whilst 40 students applied this seems a small number in comparison to the 700 plus students in the cohorts at the UTMB, this perhaps demonstrates that compassion interventions to enhance its understanding should not be optional and instead a key requisite on medical Schools' curricula. Perhaps one reason for the lack of compassion that has been suggested amongst some doctors is that, historically, detachment has been considered an appropriate response to suffering. Two terms have evolved and Coulehan (2009) has described these phenomenon as: '*detached concern*' (p. 585) and '*clinical distance'* (p.592). These terms are suggested to be useful in two ways: firstly being detached may act to protect the doctor from being overwhelmed by the pain and suffering they encounter and secondly to protect the patient, as it could be suggested that a doctor who becomes emotionally involved may adversely influence the medical decisions (Coulehan, 2009). The issue with '*detached concern*' and '*clinical distance'* is that the lack of an empirical evidence base upon which the terms have been based; nevertheless, the previously mentioned terms are widely accepted as a model of disease and medical

intervention (Coulehan, 2009). Inclusion in medical students' education of detached concern and clinical distance perspectives may in part answer why compassion has been found lacking in medical care. Whilst the study is an interesting one, there are key differences between the U.K. and America and as previously suggested the former has to include teaching about and for compassion in its curricula and therefore it should not be optional as Coulehan's research details.

A study by Cathie, Whan et al., in 2017 used an appreciative inquiry methodology with medical students to develop a toolkit aimed at seeking and celebrating compassionate acts. Seven third year medical students attended a 'cultivating compassion' workshop and then used the toolkit to: appreciate the (best of what has been), imagine (what might be), determine (what should be) and finally create (what will be). The aim of this activity was to assist students' understanding of the impact that observing compassionate acts in practice had upon them (Cathie et al., 2017). Emerging themes were: differentiating between compassion and normal human behaviour and the hidden curriculum of health professional's behaviour. Seven students were asked to record what they perceived to be compassionate acts. Students recorded what had been observed, who carried out the act of compassion, whom it was aimed at and how it made them feel as an observer. Over three weeks these acts were regularly uploaded onto a private, social media groups. The students could read each other's witnessed acts of compassion and this generated discussion recorded on the social media platform. Overall, 34 acts of compassion were witnessed across the different clinical settings and four major themes emerged from the data: team compassion; patient-centred compassion; peer compassion and patient- to-patient compassion. Whilst this study is useful in asking medical students to actively seek out and observe acts of compassion in practice it does not fully explain how this would work as a trajectory for a compassion pedagogy.

One student described that their idea of an act of compassion was when a doctor brought in biscuits for everyone. Arguably this is just an act of kindness and further emphasises the lack of understanding about compassion, it is useful then to consider how the value may be enacted through theory and practice.

2.6 Enacting compassion in theory and practice

Midwifery education has equal time in theory and practice during the three year course. Alongside the literatures already presented, role-play based learning emerged as a pedagogy that lends itself to midwifery with its focus upon face-to-face interactions with women and families. Importantly for this study its propensity to support learning about and for compassion. Role-play is a spontaneous tactic of acting out situations with minimal planning (Swink, 1993; Catling, Hogan et al., 2016,). Role play may allow students to enact compassionate and non-compassionate scenarios; this way students can optimise their understanding of how to apply compassion in a practical way, (or how not to). Swink's (1993, p.91) point neatly sums this up: *'learners knowing theories and guidelines perfectly, does not mean that they are able to apply these to emotional situations in reality'*. He goes on to point out that role-play offers an opportunity to address any practice shortfalls. Swink argues that students are often reticent in performing role-play in front of peers as they may fear making mistakes or feel awkward. To counter this, role-play learning requires a safe space within the classroom. Swink's (1993, pp.91-97) idea is that role-play is best facilitated in three phases including: *the warm-up phase; the action phase and the closure phase*. Warming students up requires the teacher to build a rapport with them and allow students to develop trust, build a relationship with both the teacher and each other. Helpful techniques to support the warm up phase are to start

sessions with a discussion instead of a lecture and by getting all participants out of their chairs at the same time (Swink, 1993).The *'action phase'* of role-play requires two roles; one being the protagonist and the other an auxiliary; the former needs to take the lead. Swink, recommends that during this phase the protagonist and auxiliary return to the group. The learning that took place during the action phase would be reinforced through discussions focusing about how the students will apply their learning to practice.

Role-play offers the opportunity to learn and uses the affective domain. Anderson and Krathwohl's (2001) Taxonomy of Educational Learning adds context here and suggests that learning takes place using the cognitive, psychomotor and affective domains. Whilst all are equally important, as the focus here is compassion, the affective domain has most relevance. Learning in this domain with its focus upon attitudes and beliefs (Anderson and Krathwohl, 2001) may be useful to the learning about and for compassion. Learning in the affective domain is said to have taken place when the learner has: *'received; valued; organised and internalised behaviours'* (Agard-Krause, 2016, S, 37) here the practice learning.

Midwifery students' practice learning, is considered in Lave and Wenger's (1991) seminal work, Situated Learning: Legitimate Peripheral Participation, (LLP). This work drew on examples from five apprenticeship case studies: '*Yucatec Mayan traditional midwives, Liberian tailors, United States quartermasters, supermarket butchers, and alcoholic anonymous participants'* (Lave and Wenger, 1991 p.68).

The Yucatec midwives delivered ritual healing services, herbal remedies and had knowledge of birthing techniques. These midwives were notably always daughters of experienced midwives with the specialised knowledge passed down within families (Lave and Wenger, 1991 p.66). The Yucatec midwives, over time, worked from the periphery of midwifery, to full participation as a midwife (Lave and Wenger, 1991 p. 67). In other words a Yucatec midwife's daughter became a midwife, through absorbing the *'essence of midwifery practice'* together with the specialist knowledge of midwifery practice and as Lave and Wenger (1991, p. 68) put it, '*simply in the process of growing up'*.

This study of apprenticeships and the Yucatec midwives signalled a shift from viewing learning as an individual enterprise, to learning within a Community of Practice (CoP). Such learning according to Lave and Wenger (1991) starts at the periphery of the community: student midwives will begin their clinical learning by observing midwifery care. The students will then move onto participation in clinical care and finally achieve competence when measured against the education standards (Nursing Midwifery Council, 2019). The development of competence in midwifery care would support the student in gaining full membership of the CoP.

Viewing student midwives' practice learning through the lens of CoP theory may be useful to illuminate the ways in which compassion is socially constructed, enhanced and learned. In this sense then, learning about and for compassion in midwifery education, practice is a central tenet. In Wenger's (1998, p. 4) view, learning requires '*social participation',* here the active participation of students

with midwives who support and supervise their learning during the midwifery practical placements.

Learning within a CoP will not only shape what student midwives do in practice but also support them in developing their identity as a midwife. Wenger's (1998) CoP has been briefly introduced here, will be elaborated upon and frames chapter five. Additionally, in chapter five Wenger's CoP theory is used to synthesise and evaluate my own findings.

2.7 Chapter summary

The ancient philosophers debated whether virtues such as compassion are innate or learned. The position of the researcher is that compassion can be learned. Compassion is written about in all of the world's major religions and although there are nuances to the beliefs about it, most religious writers are agreed that it should be a key feature for religious followers. Suggestions that compassion is evolutionary and reproductively advantageous means that compassionate communities will thrive more optimally than non-compassionate groups.

There are many and disparate definitions of compassion, with the most common term being the alleviation of suffering. However, in recent times and in healthcare contexts newer definitions have emerged, perhaps better reflecting a more contemporary view of compassion. In an attempt to put compassion into action some scholars have suggested that either four or five steps are needed, this is a helpful approach to consider when linking theory and practice.

Compassion has not been at the forefront of healthcare until recently. This suggests why there is a newly emerging evidence base to explore how compassion may usefully be taught in nursing and medicine. Small group teaching compared with larger groups is suggested. Reflection skills, poetry, using stories of patient interactions to evoke emotions in students, placement interactions, role-play and the writing of essays to explore emotions during clinical interactions have all been presented as useful interventions for learning about compassion and the ideas associated with it. The next chapter sets out the methodology used within the research and details why and how this was approached.

Chapter three

Methodology and methods

3.1 Ethics

I was mindful that, in carrying out research, every effort should be made to protect the participants from harm. As a registered midwife and an educator, I reflected upon the Nursing and Midwifery Council's (NMC) Code (2018). The Code was useful in considering my ethical priorities for the research. It included the requirement that I must: '*respect and uphold human rights'* (NMC, 2018, p. 6). To achieve this the Code (2018, p. 7) states that '*properly informed consent'* should be gained when engaging in any type of activity. I interpreted this to include research. Therefore, the following steps were taken: prior to all aspects of the data collection, I emailed students the Participant Information Sheet ([PIS], Appendix Two, p. 241). This informed the students about the purpose of the research and what would be expected of them. Prior to any of the data collection and upon request I also gave students a paper copy of the PIS. This document signposted students to my Education Doctorate Supervisors in the event that any of them had a concern about the research. The PIS made it clear that students could withdraw at any time and that participation was entirely voluntary. The PIS stated that any inclusion of collected data, either in the thesis or any future publications would ensure students' anonymity. I also obtained written consent (Appendix Three, p. 243) from the students participating in the free writing exercise and focus group interviews. I considered that the self-administered questionnaires (Appendix Four, p. 244) did not need formal signed consent as permission may be assumed if students completed and return a questionnaire.

As a Higher Education Institute employee I read the universities' Code of Research Conduct and Research Ethics guidance (2015, 2019). In particular, maintaining the students' confidentiality was really important; as such the free writing and self-completion questionnaires were anonymous and students were asked not to record their names. Although I was aware of the students who participated in the focus groups there were no names added to the interview recordings or the transcriptions that were subsequently made. I was also aware that during the focus group interviews some individuals' emotions and thoughts might cause students to become distressed as they reflected upon their practice experiences. However, as an experienced midwife I felt able to support the students if and as required. I was also aware that my supervisors were available for me to consult with, should any issues arise during or from the research. An application was made to the School of Education's Ethics Committee. The initial application was returned and further information was requested. This is detailed below and the ethics committee requested:

- A copy of the information sent to students.
- A copy of the Participant Form.
- An exemplar of the information asking students to participate.

A favourable outcome was achieved on the 24th November 2017 and this letter is Appendix Five (p.246). I also wrote to my Head of Division; Head of School and the Director of Research to ask if I also needed to apply for additional ethical approval. All parties confirmed that additional permissions were not required other than those granted by the School of Education's, Ethics Committee.

Next, I considered my ontological and epistemological orientations for the research and importantly my philosophy of knowledge generation.

3.2 Ontology, epistemology and methodology

My philosophical orientation toward ontology and epistemology were key considerations during the research design. Ontology is the idea of social objects being examined through objectivism and considers: *'whether a social entity can and should be thought of as objective where reality is external to the social actors*?' (Bryman, 2004, p. 16).Therefore, an objectivist position on learning about the ideas associated with compassion, might suggest that it takes place peripherally to the learner. Seen from this objectivist perspective an individual would not have any influence upon being compassionate since the propensity towards being compassionate would be fixed. This does not accord with my beliefs. I attest that the ideas associated with compassion can be taught, learned and developed over time.

Alternatively and more closely aligned to my personal beliefs are the principles of constructivism, which considers: *'objects can and should be thought of as social constructions built from the perceptions and actions of social actors*'. (Bryman, 2004, pp. 16-17). In other words compassion is learned through social interactions and therefore is in a constant state of revision (Bryman, 2004, pp. 16-17). For me, this resonates with the pattern of learning and experiences that forms student midwives' undergraduate education. Students receive: theoretical instruction in the university followed by their practice placements. This pattern, of learning in midwifery education is therefore socially constructed and in a constant state of revision. This constructivist view sees reality as both objective and socially constructed; this positions my view of how knowledge is formed.

A consideration of epistemology, the theory and nature of knowledge, helps us understand what a profession might regard as the acceptable norms in knowing (Cohen et al., 2011). Scholars suggest that epistemological rules are concerned with how knowledge is shaped; the nature of it, its acquisition and finally how this is communicated to other human beings (Burrell and Morgan, 1979). Two broad philosophies premised on knowledge generation are: firstly, positivism, which is linked with quantitative research and, secondly, interpretivism, which aligns to qualitative research (Cohen et al., 2011). Positivism seeks to conceptualise and measure human behaviour associated with important variables and seeks to determine cause and effect relationships (Hammersley, 2012). Researchers adopting a positivist approach carry out quantitative research and see reality as fixed, perhaps situating themselves more closely with the natural sciences. In natural science, laws or generalisations may be recognised in relation to naturally occurring phenomena (Cohen et al., 2011). Critiques of positivism suggest that it is less applicable to the study of human behaviour (Cohen et al., 2011).

By contrast, interpretivism and qualitative researchers aim to appreciate how individuals might view their world and the different perceptions that are expressed by individuals (Hammersley, 2012). Humans make deductions and give meaning to their situation thus creating participatory actions (Hammersley, 2012). Interpretivists work from the assumption that we need to understand why individuals act in a particular way to recognise their interpretation of the world (Cohen et al., 2011).
Interpretivism does not seek to generalise about phenomena. Instead the focus is upon the uniqueness of individuals. (Cohen et al., 2011).

I reflected that actually neither interpretivism nor positivism as a single approach would best illuminate what I wanted to find out. Instead, I was drawn to Tashakkori and Teddlie's (2003) suggestion of mixing positivism and intepretivism in a mixed methods methodology, which I thought perhaps might answer the research questions better than a single approach alone. Furthermore, mixed methods may provide stronger inferences and open up the opportunity to present more diverse perspectives (Tashakkori and Teddlie 2003); this was appealing given the lack of midwifery specific research upon my topic. Another claim for a mixed methods methodology is that in combination quantitative and qualitative paradigms may each provide their own unique contribution to knowledge; this is captured in the quotation below by Felizer, (2010, p. 14) who suggests that: '*there may be both singular and multiple versions of the truth and reality, sometimes subjective and sometimes objective, sometimes scientific and sometimes humanistic'*.

Felizer's quotation underscores the point that a quantitative approach may allow for scope and scale, whereas qualitative data may offer depth and breadth to the research. This seemed to also resonate with Creswell and Plano-Clark (2007, p. 5) who state that mixed methods research: '*guides the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases during the research processes*'.

Black and Ricardo (1994) point out that '*by using a combination of qualitative and quantitative data gathering techniques, investigators can clarify subtleties, cross validate findings, and inform efforts to plan, implement, and evaluate intervention strategies'* (Black and Ricardo, 1994, p. 1066).

The approaches adopted of course depend upon the research questions being investigated (Creswell and Plano-Clark, 2007).

There was one overarching research question and three sub-questions. The overarching question was:

What and how do student midwives learn about compassion in an undergraduate midwifery course?

Three sub-questions will be explored to build an answer to this main question

i).What do first year student midwives consider compassion to be before formally studying about it?

ii) How useful did student midwives find studying a module about compassion in changing their understanding?

iii) *How does working in clinical practice influence the student midwives' learning about compassion?*

On the one hand in attempting to answer the questions starting with 'what' it seemed that a qualitative approach fitted best and may elicit in-depth student perspectives about the usefulness of being taught about compassion. On the other hand, gauging emerging trends such as 'how useful' being taught about compassion across the year groups, as reported by the sample groups, may be answered through a quantitative approach. From this it was hoped that future educational intervention strategies and pedagogy useful for midwifery education might emerge. The next issue I considered is the research sample which leads also to a discussion of reflexivity and my own positionality.

3.3 Reflexivity, sampling and positionality

There were two reasons for my decision to research students in my own university: firstly my university had implemented a module about compassion for the first time in its history (Pearson, 2018). I was the educator responsible for designing, developing, implementing and leading the compassion module. Secondly, it seemed reasonable and convenient that the data should be collected from the students locally. Discussions of reflexivity highlight the issue of the researcher being known to the students and concerns about: '*researching myself and reflecting on my personal beliefs and values both as a researcher and as a member of the researched group'* (Hamdan, 2009 p. 378).

Considering my personal beliefs was the first step in thinking about the influences that I might have upon the research process. My stance is that teaching students about compassion may enhance their awareness of it and in turn this may help them to act compassionately. Such knowledge can assist students to recognise when compassion is present or absent in clinical practice. Being aware of my personal stance related to the research was key to mitigate against these partialities and to present the findings with honesty and rigour.

I acknowledge that there are tensions in being a researcher known to the students and suggest that this may offer both benefits and disadvantages. One of the benefits of me undertaking the research was that, although compassion was being taught for the first time, I had some previous experiences in the field of designing and developing midwifery modules. Another benefit of me doing the research was my personal and professional commitment to

providing compassionate care to women and their families. Having delivered hands-on midwifery care for many years had, I believe, nurtured my passion for the topic under investigation.

There were also practical advantages of being known to the students. One of these advantages was in having relatively easy access to recruiting participants to take part in the study. On a practical level having an overview of the student timetables made it easy to check when the data collection for those agreeing to take part would be feasible.

The disadvantages of being known to participants are considered by Hamdan (2009, p. 400) who asks: *'will I be representing the narrative of my research participants or am I representing my narrative of their narratives*?' This point resonated with me constantly throughout the research process and I concluded that my interpretations and the students' narratives were inevitably synonymous. Therefore, it is not possible to extrapolate whether being known to the students had a bearing upon or made a difference to the responses they provided during the data collection. It is also not clear whether the students would have answered any differently if I was not known to them. Additionally, I acknowledge the potential of a power dynamic existing between myself and the students. As the compassion module lead with responsibility for marking the students' essays in year one; I considered how I may defend the existence of any power dynamic (Cohen et al., 2011) that may exist between me and the sample group. The phase one students had not submitted their compassion module essay at the point of data collection. Their essays would be submitted anonymously and coupled with the nameless data collection, I considered that in

some way this mitigated for a power dynamic between me and the phase one sample group. I also did not mark this group's essay submission and instead another member of the module team marked the essay. The year two and three students included in the study had submitted their essay long before my data collection took place. Nonetheless, being known to the students is considered a limitation of the research and will be further discussed in chapter six, (6.8, p. 193).

In relation to the study sample, I needed to consider the nuances of each of the three research phases. Briefly setting out the three phases here, they will be further detailed in (3.6, p. 72). Phase one comprised of a free writing exercise framed around set questions; phase two included self-completion questionnaires and phase three consisted of three separate focus groups.

The sampling techniques considered were, probability, non-probability and purposive sampling (Tashakkori and Teddlie, 2003). Probability sampling techniques seek to randomly draw from a wide population and make generalisations (Tashakkori and Teddlie, 2003). A better fit for the sampling strategy for the research, despite it not ensuring generalisations could be made, was non-probability, purposive sampling. The intention was to target students in; years one; two and three as they could comment on the matters of interest germane to the research. This was more important than it being representative of the wider population.

The nuanced sampling strategies adopted for each of the research phases now follows.

3.3.1 Phase one, free writing-sampling

Non-probability, purposive sampling (Cohen et al., 2011) were used for phase one of the research. The January intake of students were selected as they had not been taught about compassion or as yet been into practice. Therefore, only these participants could have answered the research question:

i).What do first year student midwives consider compassion to be before formally studying about it?

3.3.2 Phase two self-completion questionnaire, sampling

Non-probability and purposive sampling were also used to select these students. The year one January intake were selected to take part in phase two of the research. I also decided to survey the September intakes of students in years two and three. September cohorts were considered to be the most appropriate sample as they have the largest number of students compared with the January intakes who have smaller numbers of students in the cohort. Purposive sampling of the entire cohort was considered to take account of student variation. This variation included: students from across the United Kingdom (U.K.); with a range of ages; diverse backgrounds, ethnicities and cultures. I therefore concluded that these students could be considered, to some extent, representative of student midwives on many undergraduate midwifery courses throughout the U.K.

3.3.3 Phase three focus group, sampling

To recruit the sample for the focus groups, again, non-probability purposive sampling was used. Although these students had self-volunteered they represented students from each of the three year groups.

Whilst Cohen et al., (2011, p. 437) point out that sampling contributes to the success of focus groups and that each participant should be a *'bearer of the particular characteristic required',* for this research it was not considered that any student would contribute anything more meaningful to the data collection than any other participant. More importantly, I took the view that students who had volunteered to attend a focus group in their own time were individuals interested in compassion and to whom it mattered. This may be considered a limitation of the research as it may have been useful to collect the perspectives from students who did not consider compassion to be important as well. Having given a rationale for the sampling techniques that were used, the next step is to consider issues of the trustworthiness, reliability and validity of the research.

3.4 Trustworthiness

Trustworthiness within qualitative research refers to the honesty and accuracy of the data being presented (Cluett and Bluff, 2000). In other words there should be an '*audit trail'* which includes each step of the research (Cluett and Bluff, 2000 p.160). Furthermore, the research should have transferability so that it might be applied to other similar settings. In accordance with this, this chapter has sought set-out the transparency of the research and its applicability to other comparable midwifery education settings.

3.5 Reliability and validity

Reliability is the '*consistency that a tool can measure what it intended to in the chosen environment'* (Cluett and Bluff, 2000 p.74).

There are also four factors to consider; *memory, motivation, communication and knowledge* (Cluett and Bluff, 2000 p.74). For example the students' memories of how useful the compassion module had been to them may have been clearer for some students and less so for others. The reason for variations in recall were due to the varying lengths of time between groups and since students had studied the compassion module; for example in year one it had been six weeks, year two, thirty seven weeks and year three sixty one weeks. This could be considered a limitation of the research. Other considerations were that the students may have lacked motivation or an interest in responding to the questions asked. However, as they had undertaken a module about the importance of compassion and were going to be future midwives, I hoped this was not the case. I also considered that the students might not understand the questions being asked or have the knowledge to answer them.

Mitigation for these two issues were taken during the questionnaire design and my aim was to make the questions both simple and suitable for students in all years to answer. Whilst there is a suggestion by Cluett and Bluff (2000) that to determine reliability the questionnaire can be repeated with the participants a few weeks later to ensure that the responses were the same, I did not think that this was either feasible or necessary. I did, however, read through the completed questionnaires to check students were answering as anticipated. There were no anomalies noted during this process.

Validity is also a measure that should be considered in relation to questionnaires, particularly as it should measure what was intended (Cluett and Bluff, 2000). Consideration also needs to be given to both *content validity* and

criterion related validity (Cluett and Bluff, 2000 p.75). Content validity describes the representativeness of the phenomena being studied. This can be difficult to guarantee, however subjecting the questionnaire to experienced researchers can be useful (Polit and Beck, 2016). This was achieved during the questionnaire; free writing and focus group question's development and prior to their use. Each of the data collection tool's content were reviewed, discussed and evaluated alongside my supervisors. This resulted in several iterations of the tools being made, during their development and before the final versions were completed. A pilot study was considered but not used to test the data collection tools prior to use in the study. This was premised on the idea that the tools had already been subjected to several changes and their efficacy tested out with my supervisors. Criterion-related validity was difficult to achieve as this describes the extent to which the questionnaire performed against data already collected by other measures (Cluett and Bluff, 2000). As this research was novel in midwifery, there was nothing to compare it to. Some studies described in chapter two (2.5, p. 38) had used questionnaires to collect their data and to elicit perspectives on compassion. Therefore, I considered that at least some data had been successfully collected previously using this method.

3.6 Data Collection methods and triangulation

A mixed methods approach lends itself towards the triangulation of both quantitative and qualitative data collection tools (Cohen et al., 2011, p. 195).

Triangulation of the datasets were aimed at gaining a view of student midwives' understanding about compassion from theory and practice. Three methods were used to collect the data: firstly a free writing exercise; secondly a self-completion questionnaire with both quantitative and qualitative questions and thirdly, three semi-structured interviews carried out in separate focus groups. Table 3.1 below shows the participant numbers, data collection dates and the numbers of questionnaires returned.

Table 3.1 Methods, numbers of participants and the data collection dates

	Phase 1	**Phase 2**	**Phase 3**
Year	Free writing exercise	Self- completion questionnaires	Focus group interviews
1	12/01/2018 Participants 24/24 (100%)	16/04/2018 Questionnaires distributed: 24 Questionnaires returned: 22 (92% response)	19/04/2018 6 participants
2		05/03/2018 Questionnaires distributed:33 Questionnaires returned: 30 (91% response)	19/03/2018 4 participants
3		14/03/2018 Questionnaires distributed: 29 Questionnaires returned: 29 (100% response)	29/03/2018 6 participants
Total	**24**	**81**	**16**

3.6.1 Phase one, free writing exercise

In the first week of the Bachelor of Science (BSc) midwifery honours course, prior to being taught about compassion, I invited students to participate in a free writing exercise. This comprised a number of open-ended questions, which meant that the students could respond in their own words and without restriction (Cohen et al., 2011). The questions are displayed in table 3.2.

Table 3.2 Phase one, free writing questions

Q1.	Q2.	Q3.	Q4.	Q5.
Can you write what you think compassion is?	**Can you think of time when you have been compassionate? Can you give some examples?**	**Can you think of time when you have <u>not</u> been compassionate? Can you give some examples?**	**Do you think that compassion can be learned?**	**Is there anything else that you would like to add?**

These students were the only participants that I could have elicited this data from as those in years two and three had already undertaken study about compassion. This phase of data collection aimed to recognise what students understood about compassion before any formal teaching took place. Students were informed about the research via email on day one of their course and this offered time for them to consider taking part. The free writing took place on the Friday of their first week, prior to the compassion module starting the following week. The activity was completed in class time and the students' responses to the questions were handwritten by the students. All twenty four students took part. Collecting data through a free writing approach seemed appropriate for phase one of the data collection. The questions were aimed at allowing the

students to offer new insights and share their thoughts about compassion. The five questions, as shown in table 3.2 were displayed on power point slides in class. The free writing exercise permitted students to write in response to the questions asked; the answer could be as long or short as they wanted. I asked them to write freely and not worry about spelling or grammar as I merely wanted to gain their understanding about compassion. I asked them to number their questions, one to five. Numbering the questions meant that later, I was able to identify the questions and subsequently collate them for the data analysis. Finally, I numbered each students' writing from 1-24 representing each participants' contribution. This numbering allowed me to easily identify the data. This was particularly useful to assist the inclusion of the student's individual quotations in this Thesis.

Question one was aimed at eliciting students' baseline understanding of compassion; questions two and three asked them to think about a time when they had been compassionate or not. In question four I was keen to know if the students thought that compassion was learned or innate. Finally, and in the event I had overlooked asking the students anything they wanted to say, they were asked to add anything else. Before moving onto the next question I waited until I could see that the last student had finished writing. The time taken for the students to answer the five questions took fifty five minutes.

Having collected data through the free writing questions with the year one students, I waited until after completion of the compassion module and their first practice placement, before inviting them to complete the questionnaire (Appendix Four, p. 244).

3.6.2 Phase two, self-completion questionnaires

The same questionnaire (Appendix Four, p. 244) was given to students in all three years. It was hoped to highlight any influences that the teaching about and for compassion and students' practice placements had upon their understanding about compassion. The basic ideas of questionnaire design according to Polit and Beck (2016) were followed. Both open-ended and closed questions were included. The closed questions had a range of fixed response alternatives that the students could select. The questionnaire was prefaced by an introductory comment regarding the rationale for the study. The questionnaire asked students to circle their age category and the year they were in. I decided against asking for students' gender as there were only two males on the course and I did not want to compromise their traceability. The questionnaire formatting was an important administrative matter to consider. Polit and Beck (2016) warn against adding too many questions and suggest that spacing should be considered. Students were also given an additional, blank sheet of paper to continue their answers if required and so as not to limit their answers. No one used the blank paper, perhaps, suggesting that the questionnaire had been formatted correctly and was the right length. A total of six questions were asked and set out over two sides of A4 size paper. I considered that the questionnaires should not be too long as this might risk the students' losing interest whilst answering.

According to Polit and Beck, there are four aspects worthy of consideration in the design of self-completion questionnaires (2016, p.362). These are *clarity, ability of respondents to give information, bias and sensitive information*. To ensure *clarity,* the questions were worded simply and clearly so that the students were

able to understand what was being asked. I also reflected the *ability of the students to give information* may be related to their personal experiences and understanding about compassion. To try to reduce *bias* the questions were neutrally worded and jargon free; the use of loaded questions were avoided. Finally, I considered that the questionnaires were not aiming to elicit any *sensitive information.*

Students were asked to tick a box for each question in relation to different aspects of compassion and whether any 'difference' to their understanding had taken place. These were framed as: *'yes a lot'; 'yes a bit'; 'not much' and 'not at all'.* The reason for using this type of wording is that I wanted a simple and clear measure of whether there had been a change or not to the students' understanding of the stated topic in the question being asked. This type of questioning was loosely based on the Likert scaling technique described as consisting of: *'several declarative items that express a viewpoint on a topic'* (Polit and Beck, 2016 p.356). Alternatives such as the agreement style questions asking for respondents to either: strongly agree, agree, or disagree (Polit and Beck, 2016) were not considered to be specific enough to answer the stated research questions and so this style of questioning was rejected. The questionnaire was reviewed by my supervisors prior to using it with the students. Additionally I asked a colleague to test the questionnaire and there were no further or required amendments identified from this. This aligned to

Polit and Beck's (2016) recommendation of testing questionnaires before using them with the participants

To distribute the questionnaires I identified when the students were attending theory sessions. Following this I set some dates when I would hand-deliver and collect the questionnaires during the same day. I considered this may optimise the response rate, which is noted can be one of issues with collecting data using this type of tool (Polit and Beck, 2016). Hand-delivering the questionnaires assisted me in collecting the data around my workload and this was important as the research was carried out additionally alongside my full time role. I gained permission from colleagues in whose sessions I planned to distribute the questionnaires. These colleagues were asked if I could have a few moments at the start of their session to explain what was required of the students followed by the questionnaire's distribution. I returned to the classrooms a few minutes prior to the end of each session and collected the questionnaires. Additionally, I had emailed each student and sent a copy of the PIS for them to read in advance; paper copies were also given out as requested. This approach ensured that a large number of students could be targeted over a relatively short time period of time. At the same time I collected the completed questionnaires interested volunteers were asked to take part in phase three of the data collection. Interested volunteers were asked to add their name and contact details to a circulated sign-up sheet. Volunteers for phase three of the research were informed they would be contacted later and with further details.

3.6.3 Phase three, focus group interviews

The focus groups also contributed to the generation of qualitative data. It was expected that this method would prompt the students to expand on their views of compassion drawing from their experiences of studying the compassion module and their clinical placements. The emphasis of the focus groups was to allow students to reflect upon their own experiences of compassion and give their personal views. Using focus group interviews offered not only a triangulation of the methods; importantly it also allowed an opportunity to gather more in-depth information about compassion from the students that had not been captured by the free writing data or questionnaires. Furthermore, these group interactions around compassion aimed to offer a collective rather than an individual view as the students stimulated each other to think more deeply and perhaps initiate others to add to the conversations. Such group interaction according to Cohen et al., (2011) allows for participant-led data to emerge and reduces the researcher predominating. Another strength of focus groups is the potential of producing a large amount of rich data in a short period of time and at a relatively low-cost (Cohen et al., 2011). Moreover, focus groups may provide a more comfortable environment than individual interviews; in turn this may mean that participants are more willing to divulge sensitive information (Cohen et al., 2011).

To facilitate the focus groups, I booked meeting rooms in my own department and used a voice recorder to record the interviews. I asked for the students' permission prior to recording the interviews. I did consider when was the best time of day to invite the students to attend, the focus groups; either before or

after their lectures. I acknowledged that either end of the students' day perhaps posed constraints for those with care commitments. Therefore, I asked the students what the best time for them would be. I went with a consensus of before the lectures started and in the morning. Each of the focus groups commenced at 08.30 am and finished just before 10.00 am. This allowed students to travel into university and onto their respective lectures. I provided students with breakfast and beverages due to the early start time of the focus group.

Before each of the interviews I gave some background information about the research and the aims for the focus group; I also reminded students that they were free to leave at any time during the focus groups, though none did. The issues of confidentiality and student anonymity were reiterated and I asked students to talk freely and advised that no answers were either right or wrong.

The data from the interviews intended to gather opinion, attitudes and values, which is described by Cohen et al., (2011) as a strength of focus groups. I was not completely new to focus group interviews and in the past had been a participant myself for midwifery research. I also consulted the literatures ensuring that I was informed about best practices. The first decision was how many focus groups should be conducted and with whom. I concluded that a total of three focus groups would be suitable and these were carried out with students in their own year group, for example; year one, two and three. Cohen et al., (2011) comments that several focus groups are preferable to one as this offers the opportunity to know whether the outcome is unique to one group.

Therefore, facilitating more than one focus group seemed best practice. It also allowed for comparisons and differences between the groups to emerge. This was important to me as I wanted to know if there were any differences between groups related to the time sample group's time on the course.

The literature about the participant numbers at a focus groups sits in tension with Morgan (1988, p.43) recommending between four and twelve participants. Conversely, Fowler (2009, p.117) suggests that between six and eight people are preferable. Other considerations are that if there are too many participants it can be difficult to manage, whereas too few can mean that the *'intra-group dynamic may exert a disproportionate effect'* (Cohen et al., 2011, p. 436). These ideas in mind; to avoid too few attendees I did not restrict the numbers on the volunteer sign-up sheets and in the first instance over recruited. If it became necessary to reduce the numbers I was prepared for this and would have selected a smaller sample. The reality was that the numbers in each year group reduced as some students dropped-out in the weeks leading up to the interviews. In the end, six students attended in year one and three with four taking part in the year two focus group. The numbers of participants therefore, generally accorded with the literature's recommendations (Morgan, 1988, p.43).

Ahead of the focus groups as the venue was my own department at the university, colleagues were informed out of courtesy and in advance. On each day of the focus group, I put a sign on the door emphasising that interviews were in progress, preventing any interruptions.

Considering best practices for the actual interviews, I noted the requirement for a skilled interviewer described by (Cohen et al., 2011, p. 437) as a '*moderator'.* I decided that this role should be undertaken by me. I considered myself, although a novice researcher, as an experienced educator familiar and skilled at facilitating group discussions. These skills would be invaluable in prompting the students to speak, encourage their thinking and reflection about the topics under discussion.

The limitations of the focus group as a data collection method were also acknowledged, including their inability to yield numerical data that might be generalisable. I reflected, although this was a valid point the questionnaires would potentially reveal some numerical data for the study (Cohen et al., 2011) I also considered that some of the students might be dominant members of the group and not allow everyone to participate. To mitigate this, after each person had finished speaking. I often used the phrase: '*so what do others think*?' Furthermore, the aim of having students in their separate year group was to ensure that they felt comfortable speaking in front of their peers during the discussions.

Consideration was given to the types of interview that could be conducted within the focus groups, namely, unstructured or semi-structured. On the one hand the unstructured interview allows for the researcher to proceed without any preconceptions of the flow and these are described by Polit and Beck (2016, p. 340) as '*conversational and interactive'*. On the other hand the unstructured interview allows for the researcher '*who does not know, what they do not know'* about a particular phenomenon (Polit and Beck, 2016, p. 340).

In this type of interview participants are allowed to tell their story with little interruption from the moderator. This interview style did not seem to fit with the research questions under investigation and so semi-structured interviews were used. The semi-structured interview allows for a specific set of topics to be covered (Polit and Beck, 2016). Although I had a broad idea about what I wanted to ask the students, I had no idea of the answers students would give.

As a trainee researcher the use of a semi-structured interview offered me a framework pertinent to my research questions. The interview schedule and script is detailed in Appendix Six (P. 247). It was prepared in advance and contained a total of ten questions, plus a number of sub-prompts. This script was not meant to be prescriptive or lead the discussion, however; the purpose was more to keep the conversation flowing and focused upon the topics. Not all of the questions were asked within the focus groups as it largely depended on the direction of conversation on the day.

My role as the moderator was to encourage the students to talk freely in response to the questions being asked. The duration of the focus groups were determined by the pre-arranged times. The close of the interviews were dictated by students onward lectures, which in reality gave approximately 60-90 minutes for each of the interviews. This accords with the literatures, which suggest that interviews lasting longer than 90 minutes may mean that participants lose interest (Polit and Beck, 2016). The duration of the year one interview was 50 minutes; year two's 58 minutes and the year three's lasted for 64 minutes.

Facilitation of the focus groups offered the opportunity to learn more about the students' views about the research topic than the other methods used. During the focus groups students not only responded to me but also to each other. Interestingly not all the students shared the same opinions or experiences within practice and this was largely determined by where their practice placements had been.

3.7 Data Analysis

It has to be acknowledged that I was known to the sample groups as the compassion Module Lead and this may have presented a potential for bias. This has been made transparent and has been a consideration for each aspect of the research and highlighted throughout this thesis. I was mindful of what Fleming (2018, p.316) suggests and not to arrive at premature conclusions based upon the *'insider researcher's'* own pre-conceptions of what the data may reveal. Moreover, insider researchers may be too close to the data and take for granted the *'tacit patterns' and 'regularities'* they expect to observe in the data (Fleming, 2018 p.316). Although known to the students, I approached the data analysis with an open mind of what may emerge. My two supervisors were also '*critical friends'* (Fleming, 2018 p.316) during the data analysis stage both questioning and challenging my assumptions of what the data was revealing.

The data analysis in mixed methods research should comprise of analysing the quantitative and qualitative data through the accepted respective method (Tashakkori and Teddlie, 2003). Both, quantitative or qualitative requires similar initial steps in preparing the raw data.

These steps are described as: '*preparation; exploration; analysis; representing the information and finally validating it'* (Creswell and Plano Clark, 2007, p. 129). These steps will provide a framework for the following data analysis section.

3.7.1 Phase one, free writing data analysis

The *Preparation of the data* for the free writing consisted of firstly typing up the students' hand written responses into word documents. I numbered each respondent from one-24 to represent the individual students. This information was placed into a separate table for each of the five questions, which facilitated all of the responses onto one document. Following this, the *data were explored* by reading and rereading together with highlighting recurring words and seeing their collocation to others. A note was made when words were used frequently by the students. Finally, the data were analysed by considering the interrelating themes and categories. The data analysis is represented in the next chapter; it followed the principles of coding and thematic analysis. *Analysing the data* was undertaken manually as this type of analysis lends itself to social construction theory. Furthermore, the emerging data becomes the events; realities; and meanings as participants' experiences emerge (Braun and Clarke, 2006, p.9). Therefore, this approach for the data's analysis seemed to fit well with my ontological and epistemological beliefs.

Thematic analysis is considered a '*flexible approach'* to analysing qualitative data, however, Braun and Clarke caution this does not mean an '*anything goes approach*' (2006, p. 5).

This can be a limitation of thematic analysis if it is not carried out rigorously. The flexibility of thematic analysis means that the researcher can determine the themes. The key quality measure is the consistency in how this is carried out. In making thematic analysis transparent prior to the analysis stage, there are a number of key decisions to make (Braun and Clarke, 2006). These include what will constitute a theme and how this will relate to the research questions. The size of a theme is less important than the idea of it capturing something important related to the research questions. The *'researcher's judgement'* is crucial in this regard (Braun and Clarke, 2006 p. 10).

The type of thematic analysis decided upon for this research was what Braun and Clarke (2006, p. 11) describe as '*a rich description of the data sets'* that aim to show the important and principal themes. Benefits of this approach are for its application to 'new' research and when participants' views on a topic are unknown.These findings are presented in question order in chapter four, (4.1, p. 91). The emerging sub-themes are then analysed in chapter five, (5.3, p. 123). Additionally, the number of students contributing to each of the themes are also stated. In terms of *validating the data*, I did not ask the students to reread their initial free writing responses. This was because the following week they would be studying the compassion module. Moreover, this may have led them to change their initial responses informed by the teaching and thus preventing their pre-course perspectives about compassion.

3.7.2 Phase two, self-completion questionnaires, data analysis

The questionnaires generated both quantitative and qualitative data; each were dealt with separately. Firstly, I numbered each year groups' questionnaires

starting at and one ascending up to the number of students in that year group. This allowed me to easily locate the comments as and when required. In p*reparing the data's* qualitative comments I formulated a table for each year group and added the generated comments for each question. I also added the student's age group. This meant that the data was in one place. These data were then coded as described for the free writing analysis in chapter three, (3.7.1, p. 85). Once the lists of words were generated they were added to a table and different coloured fonts were used to support the analysis. Once combined in this way they could be further refined and organised into themes. Also any differences between ages and year groups could be ascertained.
The quantitative data were placed into separate tables in year order; one, two and three together with the students' age groups. These can be found in Appendices seven; eight and nine (pp. 250-252).

3.7.3 Phase three, focus group's data analysis

Preparing the data for analysis included listening to the interviews. Cohen et al., (2011) recommend doing this soon after the event. The voice recordings from the interviews were downloaded; listened to several times and later transcribed. This was as close to the interview dates as possible and in preparation for the data analysis that followed.

Listening to the recordings revealed to me that some data contained sensitive and confidential information related to the students' practice placement areas. This meant that although initially I had planned to outsource this part of the

process to save time as the Education Doctorate was being undertaken in addition to my full time role, I had to change my original plans. Therefore, to maintain confidentiality for the students and midwife mentors the transcription of all three interviews were undertaken by me. Whilst, typing-up the transcription was extremely time consuming and labour intensive; it became apparent that by listening to and transcribing the recordings; I became really familiar with the data. Additionally, as I had facilitated each interview, the group members' voices were easily identifiable and this assisted the transcription process.

The recordings were typed into Word documents and an excerpt of one of these may be found in Appendix Ten (p. 253) (Excerpt of Focus Group transcript).
A transcription machine was used and this proved invaluable as it allowed the recordings to be paused or rewound and so assisted me to type up the dialogue. Each student was assigned two different symbols and a number which, represented their year of study; for example, =/3. This approach allowed an identification of the students' narratives. What is more this maintained the students' anonymity and also maintained confidentiality.
Exploration of the data was the next step. There is not a 'single' or 'correct' way to present qualitative data, however, it should be '*fit for purpose'* (Cohen et al., 2011, p. 537). Once all of the transcripts had been typed-up I read and listened to them simultaneously. This, allowed me to check their accuracy and make any necessary amendments.

Following this, the data were coded (Braun and Clark, 2006) and I did this by using a highlighter pen and post it notes. I highlighted words or phrases on the

transcripts that linked to the research questions. These words and phrases formed long lists, which I further, refined by putting them into categories until finally the overarching themes became apparent. These approaches followed the principles of coding and thematic analysis.

Representing the data analysis was achieved by organising the findings into the themes; these are critically analysed in chapter five. Verbatim quotations from the students are presented in chapters four and five with the intention of staying true to the students' original words. An important aspect of the research for me, was to present the students' voices and, in doing so, hopefully illuminate their understandings about compassion. Polit and Beck (2016) suggest that there are decisions to make about the analysis of focus group data such as: will the whole year group be the unit of analysis or the individual participants? Some scholars argue that the unit of analysis is the whole group (Morrison-Beedy, Cote-Arsenault et al., 2001). Others contend that the unit of analysis is both the group and individual participants (Kidd and Parshall, 2000).
Agreeing with the latter scholars, both the group and individual participants were taken as the unit of analysis. During the interviews it was clear that some students only contributed following on from what someone else had said.

Validating the data, presented an issue for consideration, namely, whether to ask the students to read and validate the analysed data or not. I decided against this idea due to a number negatives associated with this approach including: that the students may not have clear recall of the interviews.

Additionally, they might have changed their minds about what they said initially (Whyte 1993, p. 362).

3.8 Research Constraints

There were a number of constraints associated with the research. Namely, to complete the Professional Education Doctorate within the specified timeframe the research questions were developed so that they could be answered within this period. Additionally, cohorts of students were selected that I considered able to answer the research questions and during each phase of the data collection. All related research costs were met by me.

3.9 Chapter summary

This chapter has acknowledged the ethical issues that have been adhered to in carrying out the research. The methodology and my philosophical orientations related to this, with a justification for a mixed methods approach, have been presented. The data collection tools and how these were used have been discussed in order to offer a transparent 'audit trail' for the research. The next chapter presents the emergent findings and results.

Chapter four: Findings and results

This chapter presents the findings and results emerging from phases one, two and three of the research. The findings are presented here and analysed in depth, in chapter five. The main focus of this chapter is to highlight how student midwives may learn about compassion during their midwifery education.

4. 1 Phase one, year one: free writing exercise

Phase one of the research aimed to elicit students' understanding of compassion as newcomers to the midwifery course. This phase's data collection is explained in chapter three, (3.6.1, p. 74). The entire cohort participated in this phase of the research; 24 students in total.

The key findings, over-arching themes and patterns from responses to the five questions in this task (3.6.1, p. 74) are presented below question-by-question. Where student quotations are used to exemplify a theme, individual students are identified by a number.

4.1.1 Question one: can you think what compassion is?

a. Empathy

Thirteen students equated compassion with empathy. They stated that empathy was important for women and their families and the students wrote about the importance of seeing things from different perspectives.

b. Relationship building

Twenty three out of the 24 students thought it necessary to initiate compassion with women who were experiencing midwifery care, for example:

> *'compassion is being friendly and kind during childbirth, encouraging but not being bossy' (10).*

In developing compassionate relationships some students considered further pre-requisites were needed such as having:

> '*feelings of respect and non-judgement'* (23) and
> '*treating someone with understanding'* (24).

In relationship building the word '*ability*' was used by three of the students:

> *'the ability to sympathise'* (2); '*ability to carry out a job to the highest standard'* (5) and '*the ability to share feelings and emotions'* (12).

The action of '*being*' was stated by four students:

> '*being passionate'* (4); '*being understanding'* (9); **'***being able to see things from another person's view'* (19); '*being empathic and considerate of mother's needs'* (21).

c. Caring and kindness

Some aspect of caring, care and kindness needed for compassion was stated in nine of the responses and some of these appear below, including:

> *'it is a kind and caring response'* (3).
> 'B*eing friendly and kind, being respectful to a woman and their circumstances'* (14).

Another thought that:

> '*compassion is from the feelings of deep care' (23).*

Three responses described that care included:

> '*giving continuity of care'* (1);
> *'compassion is giving care whole heartedly and giving excellent care' (17)*

Another said:

> '*giving the right care'* (7).

Other actions relating to care were:

> '*a caring response'* (3) and '*being caring'* (8).

d. Time

Six responses mentioned that time was important for compassion and one student considered that this involved:

> *'dedicating a lot of time' (17).*

e. Communication skills

Four students considered that a range of communication skills were needed to be compassionate and one explained:

> *'to be compassionate is to have good communication skills, listening being the most important' (9).*

Another student said that when communicating it was important to:

> *'give all the information needed with honesty and openness (14).*

f. Treating people as individuals

Four responses focused upon the word 'individual' and three of them were:

> *'treating people as individuals'* (6); *'compassion means having an individual interest in other people'* (20); *'exploring an individual's needs'* (13).

4.1.2 Question two: can you think of a time when you have been compassionate? Can you give some examples?

Some overlap of the sub- themes in Question one and Question two were apparent including: communication; caring and kindness and treating someone as an individual. One student did not answer Question two.

The remaining twenty three responses reported compassion as something that could be shown to someone the students knew. This included: work relationships or whilst they had been doing volunteering work.

A person known to the student in a work capacity was cited in nine responses. Including:

> *'as a care worker I often had to go above and beyond within my workplace'* (5).

Another said:

> *'I had to consider his frustration and feelings whilst also considering my own feelings'* (20).

Examples of showing compassion in a voluntary setting was given in three responses, and:

> 'w*hilst volunteering with new mums I was an open ear to the ladies with problems'* (11).

Someone known to the student such as a family member was cited in 11 responses, one is shown below:

> *'caring for my Grandad at the end of his life' (8).*

As with Question one, communication was a key thread. Five respondents mentioned the word talk or talking and amongst these comments were:

> 't*alking and reassuring her'* (7) and 't*ime to talk'* (9).

Eight students considered that communicating through listening was key to compassion and these quotations included:

> *'I listened to her worries'* (10) and '*to support women the majority of time is to listen'* (15).

4.1.3 Question Three: Can you think of a time when you have not been compassionate? Can you give some examples?

Eighteen students admitted that in some manner they had not been compassionate in the past. Students thought themselves lacking in compassion by not treating others as individuals as shown below:

a. Treating people as individuals:

These students described the following as impacting their ability to be compassionate by:

'*not taking things as seriously as I should have'* (19). And: *'not paying attention' (5).*

Others said it was the:

'judgemental voice in my head' (16) and it was important: *'not to judge'* (12).

One student recognised that they had become:

'desensitised to homeless people' (3),
acknowledging this as non-compassionate behaviour.

Four of the following five students regretted their lack of understanding about mental health illness and thought this had contributed to a lack of compassion in their past. These students all reported that they:

'lacked understanding of mental health issues' (8; 17; 9; 6).

A further student linked this lack of understanding more specifically to someone who was an:

'e*x drug addict with mental health problems'* (1).

Another student added that they:

'lacked empathy for mental health conditions' (8).

and this also was congruent with this student's experiences of:

'being diagnosed with depression and anxiety myself I understand how hard it is to cope and I wished I'd have been around more and understanding' (1).

Others reflected upon a time when they regretted communicating with:

'unthoughtful words' (23).

This student described that they had lacked the:

'c*ourage to speak-up'* (18).

This had impacted upon them being compassionate in the past.Issues such as hunger and fatigue were thought to impact upon students' propensity towards compassion and two students wrote that:

> *'compassion is costly when tired' (3)* and
> '*I am not compassionate in certain situations when I am overly tired or hungry' (20).*

Twelve students admitted that sometimes their relationships had been lacking in compassion with their:

> '*Dad';* (1; 22; 9; 6);
>
> '*Brother';* (23);
>
> '*Daughter',* (10);
>
> '*Friend',* (7);
>
> '*School friends',* (17)
>
> '*Work colleague'*, (11; 12) and
>
> '*Strangers such as homeless [people], (3; 16).*

4.1.4 Question four: do you think that compassion can be learned?

Twenty one students, mentioned that compassion can be learned. The remainder included one student who thought that compassion was half learnt and half innate.

Two further students doubted that compassion can be learnt at all. Some students 'pre-course life experiences, seemingly influenced their understanding about compassion. This student reported that compassion was: influenced by:

> '*our upbringings and life experiences' (12).*

Another said:

> '*an individual's life experiences can make them more compassionate' (13).*

Adding to this idea, one student thought that individuals:

Other life experiences such as students' formal education apparently influenced two students (8; 9). It was not clear if this had been a contributor, inhibitor or the influences upon their compassion. Following on from this, role-modelling was considered necessary for learning about compassion by three students who said that:

> *'compassion can be taught and role-modelled by other people' (14).*

Additionally:

> *'if someone sees another person showing compassion....they in turn may start to become more compassionate'* (10).

One student thought role-models who were compassionate or not may influence them in the following manner:

> *'this can be learnt from someone who shows you a great deal of compassion...or someone who shows no compassion and you vow never to treat someone like this' (17).*

The final question aimed to elicit anything that I had not considered asking the students.

4.1.5 Question five: have you anything else that you would like to add?

Nine students did not respond to this question. One of the students who did respond suggested that compassion was:

> *'easier to feel than define in words'* Additionally, that '*teaching about compassion is challenging and real life situations are more beneficial than in the classroom* (15).

Others described that compassion is:

> *'very subjective and difficult to teach by academic means other than to see first-hand how one can react in a situation' (3).*

Another view was that:

'teaching of compassion is important when you are younger to instil the value' (17).

For another compassion:

'will likely have roots in someone's personality' (20).

Finally this student thought that being compassionate was:

'*an individual's choice to make'* (20).

Following phase one of the research, phase two followed.

4.2 Phase two: all year groups, self-completion questionnaire data.

Phase two of the study comprised of students in years one, two and three completing a self- completion questionnaire (Appendix Four, p. 244) first described in chapter three, (3.6.2, p.76). The same questionnaire was used with all year groups. The intention of this was to allow comparisons to be made between the students' understanding about compassion and the length of time spent on their practice placements.

Table 4.1 below highlights, the questions that were aiming to elicit: demographic information; qualitative data and those prompting both qualitative and quantitative responses.

Table 4.1 Self-completion questionnaire. Questions; demographic information; qualitative; quantitative or a combination

Question one: demographic data	Question two (Qualitative)	Question three (Qualitative and quantitative)	Question four (Qualitative and quantitative)	Question five (Qualitative and quantitative)	Question six (Qualitative)
About you, please circle your age and year of course	What did compassion mean to you before you took a module about it?	Did taking a module about compassion change your understanding of it? Please comment Yes, a lot Yes, a bit Not much Not at all	Did studying compassion help prepare you for practice? Please comment Yes, a lot Yes, a bit Not much Not at all	How do you think that working in practice has changed your understanding of compassion? Please comment Yes, a lot Yes, a bit Not much Not at all	Any other comments about compassion in midwifery?

4.2.1 Response rates

A total of 81 out of the 86 distributed questionnaires were returned across the three year groups. This represented an overall response rate (RR) of **94%**. This is further broken down by year below:

- Year one 22 out of 24 questionnaires were returned, RR **= 92%.**
- Year two 30 out of 33 questionnaires were returned, RR **= 91%.**
- Year three 29 out of 29 questionnaires were returned, RR **= 100%.**

The table below shows the response rate by students' age ranges; year of course and the length of time spent in practice when completing the questionnaire.

Table 4.2 Course year, number of weeks spent in clinical practice; response rates by age

Year of course	Clinical practice weeks	Response rate by age 18-24	Response rate by age 25-34	Response rate by age 35-44	Response rate by age 45-54	Response rate by age 55-64
1	6	9	11	1	1	0
2	37	18	6	4	2	0
3	61	17	10	2	0	0

4.2.2 Quantitative responses to the questions

The year one; two and three data sets may be found in Appendices, seven eight and nine (pp. 250-252). Eliciting quantitative data through the questionnaires aimed to offer scope and scale to the study. To produce this quantitative characteristic, the following codes: **YAL** (Yes a lot); **YAB** (Yes a bit); **NM** (Not much); **NAA** (Not at all) were developed to analyse the extent to which students' understanding of compassion had been influenced by their formal study and clinical placements. The quantitative data from the questionnaires revealed that across the age groups 35-44, 45-54 and the 25-34s that the module had either been "a bit" or "a lot" useful in helping with student's understanding compassion. Over half of the 18-24 age group across all years considered that the module had been "a bit" useful.

Across all year and age groups the majority of students found the module to be either "a bit" or "a lot" useful in preparing them for midwifery practice and for most, working in practice had changed their understanding about compassion. The quantitative data from all year groups is presented in Table 4.3.

Table 4.3 All year groups combined questionnaire, quantitative data

	Did taking a module about compassion change your understanding of it? (Q3)			Did studying compassion help prepare you for practice? (Q4)			How did you think that working in practice has changed your understanding of compassion? (Q5)		
Age (years)		n	%		n	%		n	%
18-24	YAL	6	14	YAL	13	30	YAL	15	35
	YAB	23	53	YAB	20	47	YAB	17	40
	NM	9	21	NM	6	14	NM	9	21
	NAA	5	12	NAA	4	9	NAA	2	5
	Total	43	100	Total	43	100	Total	43	101
	1 no response			1 no response			1 no response		
25-34		n	%		n	%		n	%
	YAL	13	50	YAL	13	48	YAL	15	58
	YAB	10	38	YAB	12	44	YAB	9	35
	NM	3	12	NM	2	7	NM	2	8
	NAA	0	0	NAA	0	0	NAA	0	0
	Total	26	100	Total	27	99	Total	26	101
	1 no response						1 no response		
35-44		n	%		n	%		n	%
	YAL	3	43	YAL	3	43	YAL	2	33
	YAB	4	57	YAB	4	57	YAB	3	50
	NM	0	0	NM	0	0	NM	1	17
	NAA	0	0	NAA	0	0	NAA	0	0
	Total	7	100	Total	7	100	Total	6	100
							1 no response		
45-54		n	%		n	%		n	%
	YAL	1	33	YAL	1	33	YAL	1	33
	YAB	2	67	YAB	2	67	YAB	2	67
	NM	0	0	NM	0	0	NM	0	0
	NAA	0	0	NAA	0	0	NAA	0	0
	Total	3	100	Total	3	100	Total	3	100

4.3 Qualitative data from the questionnaires

Alongside the questions aiming to elicit quantitative data there were also open-ended questions. The open-ended questions allowed students to write whatever they wanted to in response to questions: two to six inclusive. Some of the students' quotations are presented in this next section. These are differentiated by their year of study and the number allocated to the original questionnaire. For example Year (YR1) student questionnaire number (S1). The addition of the letters YR and S differentiates the students in phase two of the study from those in phase one. Results will be presented question-by-question. A critical evaluation of each theme is presented in chapter five.

4.3.1 Question two: what did compassion mean to you before you undertook the module about it?

a. Empathy and sympathy

Both empathy and sympathy emerged in response to this question. Students in all years identified that empathy was needed to be compassionate: in year one: (n=9); two (n=4); three (n=5). Sympathy was also cited by students in all year groups: in year one (n=4); year two (n=3) and year three (n=1).

4.3.2 Question three: Did taking a module about compassion change your understanding of it?

b. Communication skills

Two year one students said that studying compassion had highlighted communication as a key learnt skill and for this student:

'*it showed me to be conscious of my word choice*....' (YR1; S6).

Importantly:

> '*listening fully to the women and not multi-tasking filling out paperwork whilst the woman is disclosing something important'* (YR1; S8).

Three year two students mentioned communication. This student said that studying about compassion had made them:

> '*more aware of how you treat people and how your actions affect others and how the language you use to respect how others feel'* (YR2; S17).

Another said that studying the module had given them:

> '*an awareness of language, both verbal and non-verbal'* (YR2; S1).

No third year students mentioned that studying about compassion had assisted their communication skills. However, this will be analysed in the next chapter.

Most students in all years described some change to their understanding after studying the module about it. In year one, three students did not write any qualitative comments for question three. One student wrote that they were:

> '*comfortable before*' (YR1; S4) undertaking the module.

In year one some students' understanding about compassion had changed and:

> *'it made me think more about how to treat people and how the care they receive can affect their experience'* (YR1; S22).

Another responded:

> '*it opened my eyes to the type of compassion can be given. Non-verbal behaviour that can be both compassionate and non-compassionate'* (YR1; S17).

Eighteen students described the changes to their understanding about compassion and one student wrote that:

> *'I feel that compassion cannot be taught'* (YR2; S8).

For this second year student:

> *'the compassion module increased my understanding of the wide scope of compassion and the different aspects that also relate to compassion especially relating to resilience and burnout and its effect on being compassionate'* (YR2; S2).

For another student studying about compassion it:

> '*made me think about it more in-depth'* (YR2; S3).

The remainder of the students reported changes to their understanding as follows:

> '*the compassion module was a good foundation for caring for women and their families and has enabled me to draw on these skills in practice'* (YR3; S4).

Others said that:

> '*I recognised that compassion is fundamental in midwifery practice. I developed a greater understanding of compassion and its importance'* (YR3; S9).

And:

> '*it made me learn how to be compassionate without being patronising'* (YR3; S11).

4.3.4 Question four: Did studying compassion help prepare you for practice?

Most students in all years described, how, in some way that studying about compassion helped to prepare them for practice. A key thread emerging from this question was relationship building. Students in all years identified that compassion was needed to build relationships with the women in their care. This can be illustrated by a year one's comment:

> *'in placement it gave me a strong understanding of the kind of midwife I want to be. It also gave me understanding of what good practice should look like'* (YR1; S16).

This second year student said:

> '*it gave me the ability to critically view care I saw provided in practice and helped me to pick out aspects that I wanted to emulate. It raised for me the importance of compassionate care and gave me a greater awareness of it' (YR2; S5)*.

Two third year students identified compassion as a key midwifery skill in relationship building saying that it:

> 'a*llowed me to identify compassionate care as the grass roots of midwifery care'* (YR3; S24).

Also:

> '*I think that compassion is the bread and butter of midwifery*....' (YR3; S15).

4.3.5. Question five: How do you think that working in practice has changed your understanding of compassion?

Data analysis of the responses from this question identified the following sub-themes: empathy and sympathy, role modelling and the barriers to compassion. Each sub-theme is presented in turn.

a. Empathy and sympathy

Some students in all year groups considered that understanding others perspectives was key to compassion. This further underscores the sub-theme of empathy and sympathy in relation to compassion detailed in (4.3.1, p. 102).

Six students in year one (YR1;S12; YR1;S13; YR1;S17; YR1; S18; YR1;S21 and YR1;S22) mentioned:

> '*understanding other people'*.

In year two some of these comments included:

> *'understanding how women feel' (*YR2; S*14) and:*
> *'understanding at a vulnerable time' (*YR2; S*23).*

Another said that compassion required*:*

*'understanding sympathetically how issues impact on them, seeing it in their eyes' (*YR2; S30*).*

Some year three students mentioned that understanding was required for compassion, namely:

'*understanding of others and their needs' (*YR3; S*8) and:*
*'understanding how other people are feeling and what they are going through' (*YR3; S*19).*

Finally:

*'understanding other people's viewpoints' (*YR3; S*25).*

A number of students in years two and three described how their understanding of compassion had changed. They described either a 'level or measure' in terms of this change. These words are in presented in bold and describe how 'much' working in practice had changed the students' understanding about compassion.

In year two students, said that:

'*the effect that you have on women you care for is* ***massive'*** (YR2; S17).

This student said that it:

't*aught me to be compassionate and the* ***small*** *things that you can do to show compassion'* (YR2; S11).

Year three students' said that:

'*compassion does come* ***easily*** *in some instances but in others I have to try a bit* ***harder'*** (YR3; S14).

Others added that:

'*I feel* ***more*** *compassionate towards women than I thought I would'* (YR3; S4).

For this student it was a:

*'**deeper** understanding of what women and families go through'* (YR3; S3).

Attitudinal changes towards compassion had taken place for some students. This student reported that they were now:

'***less** judgemental and stereotypical'* (YR3; S16) and another reported that:
'*I am **more** in tune with my compassion'* (YR3; S21).

Clinical practice had changed this students' understanding about compassion due to being:

'*exposed to a **range** of experiences and situations which has made me adapt my compassion'* (YR3; S2).

b. Role modelling

Students in all years, described that the role modelling of others' in practice had helped them with their understanding about compassion.

This student said that:

'*I have seen midwives handle testing circumstances by using their emotions in a positive and productive way. Seeing compassion out in practice is helpful and has solidified all my theory knowledge'* (YR1; S8)

Another believed that practice had increased their understanding of compassion and said:

'yes, very much. I was very aware of the level of compassion during the care of women' (YR1; S1).

One year two student said that:

'seeing it in action has made me appreciate its importance' (YR2; S16).

Additionally, clinical practice changed this student's thinking and:

'*it made me realise how compassion is present in all areas, both midwife-mother care, compassion between colleagues'* (YR2; S4).

This student responded that:

'it let me see how different people showed compassion' (YR2; S3) and:

'*seeing it in action has made me appreciate its importance'* (YR2; S16).

This student concluded of compassion that it is:

'...*a skill you can only really learn in practice'* (YR2; S13).

Year three students also described how practice had assisted with their understanding about compassion including:

'I have observed lots of compassionate care and lots of uncompassionate care and the difference both has on women's experiences' (YR3; S23).

Another said that:

'*there are situations and emotions that can only be understood in real life situations and being in these situations has opened my eyes up to a lot of things to help my understanding'* (YR3; S19).

Together with role modelling, some students in all years observed some discernible barriers that had prevented compassion during their practice placements.

c. Barriers to compassion

A year one student wrote:

'*seeing reality of pressures facing midwives etc. and working within constraints of funding training capacity'* (YR1; S21).

A year two student acknowledged that:

'*working in practice and observing the pressures and stresses of a maternity unit first hand made me appreciate how compassion can slip both individually and collectively'* (YR2; S22).

Finally, this year three student said that:

'*the institution of care, the pressures on the services can prevent compassion. The tiredness and relentlessness of placement can sometimes cause burnout and deplete my ability to be compassionate'* (YR3; S9).

4.7.1 Question six: Any other comments about compassion in midwifery?

In response to this question the students' comments were as follows;

A year one student said:

> '*it opened my eyes to the type of compassion that can be given. Non-verbal behaviours that can be both compassionate /not compassionate'* (YR1; S16)

and:

> '*I have developed into a better person'* (YR1; S6).

One student considered that compassion:

> '*should be an integral part of midwifery education and continued professional development'* (YR1; S19).

Year two students said that compassion:

> *'has to be personality can only teach up to an extent'* (YR2; S7).

In addition:

> *'you can't be a good midwife without it'* (YR2; S30) and
> 'a*ll midwives should have this module'* (YR2; S24).

This aligned with another student's thoughts who said compassion:

> '*should be taught to all staff who work in healthcare as a lot of people don't show as much compassion as they should'* (YR2; S10).

Third year students also considered that:

> '*compassion is part of people. I do feel to do midwifery this would be part of your nature'* (YR3; S17).

This student now reported that compassion is:

> '*something I feel strongly about and will carry through my whole career' (*YR3; S*20) and: 'it is an essential engrained skill that every midwife should possess. It costs nothing to be kind'* (YR3; S24).

The data generated from the qualitative questions supports two overarching ideas: first, the importance of the formal teaching about compassion and secondly, the clinical practice influences. A number of sub-themes emerged in relation to the students' formal teaching about compassion including: empathy and sympathy; communication skills, role modelling and the barriers to compassion. These ideas are explored in chapter five.

Next, phase three followed the self-completion questionnaires, student volunteers who, if, interested, were asked to add their names to a sign-up sheet and to take part in phase three of the research. Three separate focus groups were facilitated for: year one; two and three (chapter three; 3.6.3., p.79). It was considered that students would feel more comfortable speaking within their own year groups. Also that students in the same year of study would have spent an equitable amount of time in practice. This was considered an important requirement for the phase three data collection.

4.4 Phase three, focus group findings

Each of the student volunteers were contacted individually via email with the: date, time and venue of when their respective focus group were to take place. These were facilitated as follows: year one, 29th April 2018; year two, 23rd March 2018 and year three on the 29th March 2018. Participants in these focus groups included: six year one, four year two, and six year three students.
As set out in chapter three (3.7.3; p. 87) the students' quotations are followed by two symbols and the year of study to differentiate between the participants.

Five sub-themes emerged during the data analysis including: compassion and understanding; organisational culture; role modelling; caring and kindness and self-awareness.

4.4.1 Sub-themes emerging from the focus groups

a. Sub-theme one: compassion and understanding

A year one student said compassion was more complicated than they previously considered. Furthermore, being taught about it alongside practice experiences had:

> '*introduced different ideas about compassion, resilience, emotional intelligence, not simple and includes many different ideas. After the compassion module you realise that you can mean to be kind* (=/ 1)'.

Another student's observations from practice were that:

> *'compassion, can be that tough love or doing the best thing for them. 'Telling them how it is rather than fluffing it up and honesty'* (=# 1).

This second year student described changes to their understanding about compassion:

> '*I thought before the module it cannot be taught either you feel it or you don't. On reflection I feel differently: 'there are tricks and tips that can make you more compassionate or aware of your compassion. Not sure if you had no compassion it would work but I do feel different at the end of the module to how I did at the beginning'* (=/ 2).

Likewise, this student said that I now have:

> 'm*ore understanding about the consequences if you were not compassionate. It's like a foundation for everything and a lot of the other modules'* (=# 2).

Third year participants described a change to their understanding about compassion and this student said:

> *'I didn't understand what compassion meant before starting the course, knew it was something to do with empathy, didn't understand that it was about making something better'* (=/ 3).

For another student it:

> '*gave me a better understanding of how important compassion is in midwifery and how much it should underpin what we do. I don't know if prepare is the right word. It helped me to kind of walk in and think ....where is the compassion in this particular interaction between people? Or where's the compassion between staff, you know it seems to have got lost somewhere. It highlighted the importance of compassion in every aspect not just the women but to everyone that you work with. I knew that I had to be compassionate and that it was a fundamental part of midwifery'* (=* 3).

For this student an action was needed for compassion and they said:

> '*it made me think of it as an action rather than just a feeling when I learnt about compassion'* (=\3).

To improve their understanding of compassion some students identified what, the teaching during the module was lacking and this included:

> '*more practice for when you are in a "beast of a hospital situation". Like when the bell goes on your first shift in the hospital and everyone goes tearing down the corridor or the compassion that you need for the parents/partner. I would say role-play, setting up the scenarios so that you can explore that situation* '(=/ 2).

In terms of the teaching about compassion this student wanted it:

> '*linking to practice more. How to ensure that you are still being compassionate in difficult situations'* (=# 2).

b. Sub-theme two: Organisational culture

A number of students described the clinical organisational cultures and how this had influenced their understanding about compassion. This year one student had observed:

> '*quite a lot of moaning, don't have time to be compassionate. 'There is frustration that the midwives don't have the opportunity to be compassionate anymore. I found midwives wanted a "get out" those in the birth centre would say I am going into community to get a life and those in community were saying I am going to retire/semi-retire. Everyone was scared of being sued at some point'* (=\ 1).

For a second year student their experience had been:

> '*mixed I'd say. There is a lot of midwives I worked with that I'd like to be like who have been compassionate and others who have not. So it's taking from who you want to be like. 'I've seen some most wonderful, compassionate midwives, do some amazing care with women, but have struggled so hard, within the framework that is the NHS now and the pressures and technology bias. Sitting behind a computer and filling out forms is a barrier to compassion'* (=#2).

Some third year students commented upon their practice placements and the organisational cultures: this student said that:

> 'm*y community team were really very, very, short staffed, very, very stressed, like it was the worst it had ever been, hopefully the worst it will ever be, all of the midwives cried on me at some point and I was actually quite good at dealing with it, it didn't really stress me out which is kind of surprising in hindsight, so maybe that was the compassion module'* (=/3).

This student reflected that:

> '*I remember being told by my? mentor that I was like too nice. She would say to me like, "I know that you really care about the women but we really don't have time for you to care about the women".' Because whenever they'd come in, obviously I'd be like "How are you feeling" and she's like, "that is a question I never ask because if you ask someone how they are feeling then you're gonna be there for ages*" (=# 3).
>
> Another revealed that:

> *'looking back the community team were really compassionate to each other they were a really good team and they really do look out for each other, so I am probably quite surprised with the busyness and they still had that, I have been to other teams where that hasn't been the case'* (=+ 3).

c. Sub-theme three: role modelling

Role-modeling from those who had supported the students' practice learning had influenced their understanding about compassion. Both positive and negative interactions were observed during their placements. This student recounted that:

> *'I don't think that compassion was a thing that was taught, and I think that some midwives might not have had the exposure to the side of compassion that we have, so they might not have been able to think about it from different aspects'* (=*1).

This same student went onto to say that they now had a:

> *'heightened awareness of compassion and it helped me to see when it was shown and when it was lacking. Verbal non-verbal cues, body language i.e. 'Turn towards a computer rather than the woman, this will not build a relationship and she will not disclose or tell you things if she does not feel connected'* (=* 1).

Another student could now see that:

> '*compassion really shines through when you are giving informed choice. You can tell the difference between someone just giving choice with compassion and these are your options'* (=# 1).

This student's experiences showed her that:

> *'the module highlights people who aren't compassionate you find yourself thinking 'You need to go and do that module'* (=/2).

With similar views, a further student had learned that:

> '*not always seeing compassion 100% of the time, I can now look at it a different way and think why did they act like that? It taught me how to look at somebody's practice and think I do want to be like that or not*" (=+ 2).

One student had a conversation about the compassion module with her mentors.

Of these interactions they said that:

> '*I found it really interesting on the midwives reactions to the compassion module because we were the first cohort to have done it and they didn't understand it whereas to me it was normal because it was all I had known. It was really oddly received. They said why have you spent six weeks on compassion and you think that's why I have spent six weeks on compassion so I don't turn out like you'* (=+ 3).

This student said now:

> '*I think I've become more aware of the lack of compassion in various situations and I've been thinking, 'that wasn't very compassionate,' you know, how things are approached, I just think, 'yeah okay, that doesn't really stand with midwifery and its compassionate values. So I don't think my compassion, my level of compassion has changed- I think it's my level of empathy, so my ability to be empathetic and think about why that person is that way, or why they're acting that way*' (=*3).

The idea of role modelling was also shown from this student's experience during the theory taught on the course:

> *'I think it's really interesting that the compassion I feel from the university lecturers are the ones that were involved in that module from the very beginning. Those are the ones that stand out for me as the ones that 'get it' in inverted commas. No matter what they are teaching you feel it'* (=+3).

d. Sub-theme four: caring and kindness

Caring and kindness emerged as a theme in phase one and also this phase. A year one student now understood that compassion is:

> '*similar to kindness but more extended, includes empathy. 'A multi-layer thing'. Didn't realise there were several layers to it'* (=\1).

Another said:

> '*I think it goes back to that thing about the women will forgive you for like, not knowing everything at this point but they're never going to forgive you, if you are not kind and compassionate. And that's what they always remember isn't it?*' (=/1).

This second year student had observed that:

> '*the obstetricians' kind of takes over a lot of the time, doesn't it? And I think the midwives are still compassionate with the care that they give the women but, the culture is more towards that obstetric-led side of things'* (=#2). This student said that: '*the care I've seen, they are sort of kind to women, it's just that the practice they're doing isn't always compassionate as it could be. So it's not as though they are horrible or disrespectful, that you know, they're being nice to them and kind to them, it's just not the compassion that I think they should be getting. It's not the full package it's part of a package'* (=\2).

This third year student said that:

> '*I think for me, I didn't realise that it was so much about yourself, as it was about other people, so I think I learnt a lot, about being compassionate to yourself before you can do it to anyone else? Be it to anybody else'*? (=+3).

e. Sub-theme five: self-awareness

The final emerging sub-theme from phase three was self-awareness. A year two student had found studying about compassion had increased their:

> '*Self-awareness on placement, it gave you a tool that you could use to build your confidence. It made me stop and think that in my gaining experiences there was a woman. Self-compassion, looking after yourself, mindfulness. 'It gave me a little protective blanket to say I need time out to process this I need to look after myself'. Asking for debrief when I saw things I didn't like or understand, the module gave me confidence to ask* '(=/ 2).

This accorded with another student's idea about self-awareness:

> '*umm I think it increased awareness of yourself in placement, I think it almost helped to build confidence, so that you could start becoming and building that compassionate role'* (=/2).

Finally, students were asked if prepared for their first practice placement again was anything not covered in the compassion module that should have been. First

year students did not identify any deficits in their learning. To further elicit their views about practice preparation I asked a prompt question of year one students including how they had prepared for their first placement. Two students described their practice preparation and one student wrote that they:

> '*didn't really sit down and think about it, things just slotted into place'* (=/ 1).

Another student admitted that they:

> *'didn't prepare, but in the first few weeks when I was on my own with women I panicked like "I was in at the deep end. Couldn't prepare to be compassionate as I did not know what I needed to improve until I had some experience'* (=\ 1).

Two further students advised that they had '*mentally'* prepared and this student had:

> 'm*entally prepared myself and thought about the things that I might face. 'Keeping my own emotions in check knowing I would need to be there for someone else'* (=* 1).

Likewise, this student had:

> *'mentally prepared in terms of resilience in case something challenging happens and you need to keep it together for yourself and the woman'* (=& 1).

4.5 Chapter summary

The findings from this research have been presented in the students' own words. The quantitative data have been described and presented in tables. In making sense of the findings in relation to the overarching research question:

What and how do student midwives learn about compassion in an undergraduate midwifery course?

The findings presented in this chapter have suggested that there are three distinct yet interrelated phases and these inform students' learning about and for compassion. These are the students' pre-course: life experiences, the formal teaching about compassion and learning about and practising being compassionate in clinical practice.

Life experiences

The findings detailed in phase one have provided some insight for the research-question:

i*) What do first year student midwives consider compassion to be before formally studying about it?*

Phase one revealed that learning about compassion starts with the students' pre-course life experiences. Additionally a number of sub-themes also reported by the sample group had informed their learning about compassion including: relationship building, caring and kindness, time, communication skills, treating people as individuals and role modelling. These will be debated and evaluated in chapter five (5.3, p.123).

Formal teaching about compassion

The findings and results emerging from phase two and three have offered some awareness of:

ii) *How useful did student midwives find studying a module about compassion in changing their understanding?*

On the one hand the quantitative data revealed that the majority of students found the formal study about compassion had been useful to their

understanding. On the other hand the qualitative data showed that the formal teaching and ideas associated with being compassionate seemingly builds on the students' existing experiences of compassion. The following sub-themes emerged: empathy and sympathy, communication skills, role modelling and the barriers to compassion. These ideas are discussed and evaluated in chapter five (5.4, p.143), role modelling and the barriers to compassion overlap with the themes in the section below and are therefore discussed and evaluated as below.

Learning about and practising being compassionate in clinical practice.

The findings from phase two and three revealed how the formal teaching about compassion had influenced the sample group's understanding of the value in clinical practice and offered some insights for the final research question:

> *iii) How does working in clinical practice influence the student midwives' learning about compassion?*

The emerging sub-themes were: role modelling, barriers to compassion, caring and kindness, organisational culture, and self-awareness. Compassion and the changes in the students' understanding of the value underscores this section. Consideration and appraisal of these themes are in chapter five (5.6, p.155). In the chapter that follows and as first introduced in chapter two (2.6, p. 55) Wenger's (1998) Communities of Practice Social Learning Theory will frame and help to make sense of the findings from the three phases of the research.

Chapter five

5.1 Discussion

The aim of this study was to answer the overarching research question: what and how do student midwives learn about compassion in an undergraduate midwifery course? This chapter is framed to discuss this question, informed by the three phases of the research process first introduced in chapter three (3.6.1 to 3.6.3, pp. 74-79). In the discussion that follows, the qualitative findings and quantitative results are brought together.

Phase one relates to the students' pre-course life experiences; phase two, explores the formal teaching about compassion, and phase three to learning during clinical practice. The phases of the research in reality are not entirely distinct from one another and so the findings have informed each of the three sections set-out in this chapter. This actually reflects that like other deep learning, learning about compassion is recursive. Students bring their pre-professional life experience to the classroom and to clinical practice; they will continue to learn both formally and informally, depending upon the situations they find themselves in. Each individual arrives at the course with different ideas and experiences of compassion; the professional education issue is how to get every student on the course to at least the minimum threshold level of understanding and practice of compassion that is expected as per the professional expectations and standards (Nursing and Midwifery Council [NMC], 2018; 2019; Francis, 2013; Department of Health [DH], 2012). It therefore seemed reasonable, as a starting point, to explore what was found in the study about the sample group students' life experiences and to consider if and how these had influenced their learning or views about compassion.

In an attempt to make sense of the students' perspectives about compassion, Wenger's (1998) Communities of Practice (CoP) Social Learning Theory is used as a theoretical framework to '*knit' the findings into an 'intelligible pattern'* (Polit and Beck, 2016 p.119). Alongside formal teaching in university, the students will also learn through social participation during their preparation as newcomers into a CoP (Wenger, 1998) first introduced in chapter two (2.6, p. 55).

5.2 The theoretical framework to highlight learning

Wenger (1998) suggests that newcomers go into, learn from and finally contribute to an existing CoP. Here, the student midwives are considered '*newcomers*' and the CoP, the midwives supporting their learning. Midwifery students, will move backwards and forwards between the university and practice. Students therefore, will also belong to a CoP within the university alongside: '*belonging to several communities of practice.....communities of practice are everywhere' (*Wenger, 1998, p.6).The focus here will be upon the midwifery practice CoP that students will learn within during their undergraduate midwifery education. In the beginning, students will start at the periphery of the CoP (Wenger, 1998). Starting as legitimate peripheral participants on entry to the midwifery course during the period of their professional education students will learn, develop and progress towards full participation of the CoP (Wenger, 1998). Learning in midwifery takes place in social groups through participating, developing competence, being accepted and finally contributing to the CoP.

Additionally, Wenger's (1998) ideas resonated with my epistemological and ontological stance, which is that learning about and for compassion is socially constructed. Importantly, that compassion can be taught and learned. In an attempt to understand how learning takes place in an undergraduate midwifery course I analysed my findings around Wenger's suggestion that learning is fourfold and these symbiotic features include: '*learning as experience' (meaning); learning as doing'* (*practice); 'learning as belonging' (community) and 'learning as becoming'* (identity) (1998, p. 5). These ideas are used as a point of reference throughout this chapter in an attempt to make sense of how students may learn about compassion.

Moreover, learning in a CoP requires not only *'participation'* but also *'reification'* (Wenger, 1998, p. 52). Reification can be achieved by '*projecting meanings' into the world and supports the learner to see that meaning has its own reality*' (Wenger, 1998 p. 58). The literal meaning of reification, is the notion of making the *'abstract into something more tangible'* (Thompson, 1995 p. 1158). Making a case for learning about compassion, then, it arguably needs to be made into a *'thing'* so that it is meaningful to the students. Moreover, both participation and reification refer to a duality that supports the negotiation of meaning (Wenger, 1998 p. 55). Wenger suggests that the negotiation of meaning is premised on the knowledge that concepts are never learned entirely from scratch. Instead, our existing experiences are negotiated through participation in the world to achieve what Wenger describes as '*negotiation of meaning' (*p. 54). Negotiating meaning is multifactorial and involves participants' interpretation of new situations followed by an action (Wenger, 1998).

Reification in brief shapes our experiences and gives them meaning (Wenger, 1998). Therefore, *'learning as experience'* (Wenger, 1998 p. 5) in terms of compassion had started long before the students' midwifery education and the findings suggest from the students' life experiences.

5.3 Life experiences

The findings from this analysis suggest that as student midwives began their midwifery course, their experiences of compassion were both highly individual and diverse, as shown by the following responses and: *'compassion is giving mothers and families the best possible care which includes explaining procedures and keeping them informed'* (1).

This quotation, perhaps, suggests that this student had started to think how compassion might fit with their new role as a student midwife.

Another said that: '*compassion is the ability to share feelings and emotions of someone else's situation. To treat people how you would like to be treated'* (12).

This student had included the emotional aspects of midwifery care in their thinking. Such differences in student perspectives about compassion as they started their education suggested something about the task ahead for their teachers in reconciling different views and linking them to better understanding of how to be compassionate as a midwife.

Analysis of the data suggests that students' views and understandings of compassion appeared to have been informed by their experiences of their own upbringing; their relationships with others; schooling and work interactions. For example, one student said: *'I think that an individual's life experiences can make*

them more compassionate' (13). This student suggested that: e*veryone has the ability to be compassionate. Some people may find it normal and automatic to show compassion.....for others, for many reasons they may not be able to be compassionate to others.... as they may have not been treated with compassion in their lives...'* (15).

This idea that life experiences influence an individual's understanding of compassion accords with work by a number of scholars who have argued that '*foundational influences'*, such as how individuals are parented, are necessary to the understanding of being compassionate (Pence, 1983, Bryman, 2004, Wear and Zarconi, 2007, Gilbert, 2009). If an individual's upbringing is within a safe and loving environment, compared with one of violence, this may offer contrasting perspectives about compassion. Such foundational influences may lead to either the presence or absence of compassionate behaviours (Gilbert, 2009). Furthermore, compassionate behaviours may be enhanced in those who have experienced past adversities, which some believe increases their prosocial attitudes including compassion towards others who are also facing difficulty (Vollhardt and Staub, 2011).

Moreover, Wenger (1998, pp.51-52) underscores all of the previous points as he suggests that *'learning as experience'* (here compassion) is not found inside the pages of dictionaries, it is in the *'experiences of everyday life'.* This proposes that the sample group's experiences of compassion as they started the course would be diverse. In fact a midwifery cohort will always include students with diverse former life experiences, some having, perhaps, faced adversity or hardship which may make them more compassionate. Each will have negotiated

their own meaning of compassion, and through reification, shaped their individual experiences. These differences highlight the need to be proactive in teaching the ideas associated with compassion, to increase understanding for all.

One student seemingly appreciated that to be compassionate was to: *'realise that not everyone is in the same place and in conversation and interaction, respecting and understanding that they may be dealing with some difficult circumstances'* (15).

Relationships with others during periods of work experience triggered this student to think when they had been compassionate in the past: 'w*hen I did a week of volunteering for the elderly I showed compassion to the service users and provided respectful care'* (6). Another student reported that their understanding about compassion for others had been informed by: 'w*orking in a homeless shelter serving food providing clothes, being compassionate and giving them time to talk and feel safe without fear or rejection or judgement showing that they are important, they matter and they are cared for'* (9).

None of the students reported that their schooling had assisted their learning about and for compassion. One student wrote that: *'I was never taught about compassion in school. I think that the teaching of compassion is important when you are younger to instil this important value for everyone'* (17).

This student's experience is in line with Cole's (2015) view, arguing that compassion is neither formally taught, nor really features during formative or secondary education. On the other hand, it is important to take account of the wide differences in people's education and the experiences that students are exposed to. Topics such as empathy, charitableness and probably compassion

are part of the history, English, Religious Education or Personal Social Health Education (PHSE) curriculum in most schools. Alongside this, is the informal curriculum with assemblies, school rules and values also seeking to emphasise these qualities. However, the sample group did not relate this earlier teaching to the concept of compassion and perhaps this is because the value is more implicit then explicit within the curriculum. It is interesting, then, that none of the sample group described being taught – or had a chance to learn about-compassion through their formal education. This absence of explicit teaching about compassion has also been an issue in healthcare contexts (Sinclair, Mc Clement et al., 2016).

Commentators have also reported little or no emphasis is placed upon compassion during medical students' education where the emphasis has traditionally been almost exclusively on those who achieve academically (Wear and Zarconi, 2007). This arguably creates an ethos of competiveness, meaning that acts of compassion and kindness go unnoticed and have no real value placed upon them (Wear and Zarconi, 2007). Creating competition within an environment dedicated to health and welfare seems to be the antithesis of compassion. Doohan and Saverman (2015) argue that compassion has to be taught during future healthcare professionals' education otherwise it will not seem important. Others go further and warn that healthcare is actually suffering a compassion crisis, with Trzeciak, Roberts et al., (2017) proposing a new term, *'compassionomics', described as the: 'knowledge and scientific study of the effects of compassionate care on health, healthcare and healthcare providers'* (Trzeciak et al., 2017 p. 92). Trzeciak, makes the case that compassion has benefits for patients across a wide variety of health conditions, the absence of

compassion may have devastating health effects and for the healthcare professionals themselves. He goes further and suggests that compassion may even be an antidote for burnout. This further emphasises the case for educating future healthcare professionals about the value.

Before the education of healthcare professionals can take place, though, the right applicants have to be selected for the available places on the education courses. Locally, places for the midwifery course are highly competitive; there are a high number of applicants who apply to become future midwives compared to the available places. Applications are firstly screened using the applicant's University and Colleges Admission Service (UCAS) personal statement, which is read and given a score according to the set shortlisting criteria. A score not meeting the minimum threshold means that the application is rejected; achieving an agreed mark set at the beginning of the recruitment cycle; means that the applicant is invited to interview. The midwifery interview is predicated on the idea that the future health workforce should be recruited using a Values Based Recruitment (VBR) approach (Health Education England, [HEE] 2016).

Amongst other values such as academic achievement, the capacity for compassion needs to be elicited at interview (Francis, 2013). The VBR is an initiative across health and social care systems which aims to ensure that applicants recruited onto midwifery courses should have values that align to the National Health Service [NHS] Constitution (DH, 2009). One way of seeking to achieve this, involves using an approach known as Multiple Mini Interviews (MMIs), which assess pre-defined personal qualities and values. However, *'the evidence base for the validity and reliability of MMIs and VBR is limited'*

(Callwood, Cooke et al., 2018, p. 138). An MMI requires the interviewees to respond to a specific question or scenario; they are given around five minutes to answer before moving to the next interviewer and station (Callwood et al., 2018). The optimum number of MMI stations is agreed to be seven and together with an equivalent number of interviewers is said to reduce interviewer bias (Callwood et al., 2018). The staffing of seven MMI stations in my university, and perhaps others, is not feasible due to the number of staff required and so five stations are facilitated. The five stations also include existing student midwives from the midwifery course and maternity service users. Alongside this a set of criteria are used to score the interviewees. Interviewers are not permitted to offer probes to the questions or deviate from the set criteria, in an attempt to ensure equality in the interviewing process.

The tools aim to elicit behaviours that demonstrate different aspects of 'The Six Cs' and NHS Constitution (DH, 2012, DH, 2015). Much thought has gone into the design and development of the recruitment and selection process. Midwifery educators, service users and current student midwives receive training around MMIs, equality, diversity and unconscious bias that aim to highlight to them their individual biases and so better prepare them for the interviews. A score is awarded to each interviewee against the set criteria at the MMI station dependent upon the response that is given, and applicants need to achieve a minimum overall score to be offered a place on the course.

It is interesting, then, to view some of the students' comments in phase one and their views about compassion, given that they had successfully secured a place on the midwifery course. One student said: '*compassion is a reaction to empathy. It is a kind caring response to a negative emotion or feeling. It can be*

innate or learned' (3). Another said: *'I think that compassion is about making a conscious effort, and taking time to understand and explore an individual's needs, whether that be physical, psychological etc.'* (13).

Many of the students' responses showed they had their own individual perspectives about compassion and this might suggest that the VBR had at least been useful in selecting future students who had started to think about the values needed for a career in midwifery. However, despite all of the recruitment measures, it is acknowledged that no tool or process is completely neutral nor can the reliability be assured. All that can really be expected amongst future midwifery students is a potential for understanding: 'The Six Cs' and aspects of the NHS Constitution. This underlines the importance and need for the formal teaching about compassion on the midwifery course.

Waugh, Smith et al., (2014) found in a survey study that qualified midwives, nurses and students believe that compassion is the most desirable attribute when recruiting future healthcare professionals. This study suggested the need to develop an evidence-based person specification for midwifery and nursing applicants recruited onto pre-registration courses (Waugh et al., 2014 p. 1195). However, there is very little further work about how to recruit compassionate individuals onto healthcare courses. These refinements may depend upon developments in teaching and learning about compassion. In other words, there could be a circularity about the current situation: more understanding of compassion in midwifery will help midwife educators be better at applying the VBR procedures. This implies, perhaps, a need to cut into the cycle and create a virtuous circle, where there is not only a better understanding of compassion but

there may the potential for improvement in midwifery education more widely (Campling, 2015, p. 1).

A number of sub-themes emerged from the analysis of students' responses in phase one. These sub-themes are set out in table 5.1 (p. 131); they represent the students' key ideas, and these have been ordered by those most important to the students in building compassion. Treating people as individuals and role modelling were equally important in the students' views. I go on to consider the significance of each sub-theme in turn.

Table 5.1 Phase one and emerging sub-themes

Phase one	Sub-themes
Life experiences	**Relationship building**
	Caring and kindness
	Time
	Communication skills
	Treating people as individuals
	Role modelling

5.3.1 Relationship Building

Relationship building was thought of as necessary by all bar one of the students. Students considering that relationship building is key for compassion is not a surprising finding as the central tenet of being a midwife is in forming professional and trusting relationships with women (Kirkham, 2015). Many studies suggest that a trusting relationship between the woman and midwife are important to the care experience, during the antenatal, intrapartum and postnatal periods (Waldenstrøm, 2004, Lundgren, Karlsdottir et al., 2009, Hunter, Berg et al., 2008). The quotations below demonstrate the varying stages that students were at in their thinking about relationship building as necessary for compassion. One student supposed that: '*compassion is very important in forming trust and relationships with a patient and if you cannot be compassionate you must not be allowed to do that role. Women who are scared need that compassion and reassurance'* (1).

This student believed: '... *that compassion is a very important skill that can show others that we are all human. It is needed in a health profession but also in everyday life. We are all important as each other. We have feelings and emotions'* (14).

Given that this student had yet to experience midwifery care in practice, this response showed insight in acknowledging relationship building as a pre-requisite for compassion; what is perhaps less clear at this stage is how they might go about developing these relationships. The professional standards suggest that students must spend at least 2,300 practice hours (NMC, 2009; 2019) caring for women and this of course involves developing relationships with them. Subsequently, this forms a very important aspect of learning during students' midwifery education. Relationships with women take many forms including those established on a transient basis such as during labour, or on a longer-term basis for example during the antenatal period, when a number of appointments are scheduled for the duration of the pregnancy. Such interactions provide opportunities for students to enhance their relationship building skills, often with hundreds of women throughout the students' midwifery education.

Hunter and Deery (2009, p. 38) point out the importance of students being genuinely interested in the women and not be a '*caring robot'*. Describing a midwives' modus operandi as robotic, might suggest someone who does not emotionally connect with women and one who just goes through the motions. A knowledge of the ideas associated with compassion including a motivation to want to help women, offers students an opportunity to build more meaningful relationships. Moreover, students on midwifery courses, just like registered

midwives, need to follow the regulatory standards including that they must: *'recognise when people are anxious or in distress and respond compassionately'* (NMC, 2018 p. 7). One student's response showed that they had already started their thought processes about relationship building and despite not yet having had any formal teaching about compassion, perhaps, showed insight by saying that: '*compassion is showing that you have thought carefully about how something relates to someone else so you can relate to them more easily and understand more based on an emotional level'* (18).

Perhaps, the most significant policy to inform relationships between midwives and women is the *Better Births* policy, which has been a key driver of maternity care since 2017. It recommends that '*continuity of carer'* should be the fundamental model of maternity care to enhance relationships between midwives and women (National Maternity Review, 2017 p. 9). No students mentioned this idea in their early responses. The *Better Births* review recommended that a *'one-to-one caseload model of care'* should be provided by a small team and that a named primary midwife should provide the majority of care (National Maternity Review, 2017 p. 40). Continuity of carer has been an aspiration of those formulating midwifery policy to shape the maternity services since the publication of the Department of Health's *Changing Childbirth* document in 1993.

When students were asked if there had been a time when they had not been compassionate, some responded that compassion had been lacking in their relationships with either family members, friends or work colleagues. A further nine students described a time when they had regretted their past decisions

made within their relationships and wished they had been non-judgemental, understanding and around more for others. A student recalled that: *'my Father was severely depressed and tried to take his own life and I was just angry at him and mad, when I look back I wish I could have supported him more and showed that I understood him and cared but I was young and it wasn't until I was older I realised how he had actually felt'* (6). This student described when: *'I was younger I worked at a fast food restaurant and didn't really want to be there. I would often slack in my role meaning I wasn't paying attention or really caring about the customers or the business's reputation'* (5).

The stark disparity between the examples cited in these quotations indicates that the students reflected on very different life experiences upon being asked to describe when they had not been compassionate in the past. This suggests that there is work to be done in educating students to become truly reflective practitioners. The consideration of reflection as necessary for compassion will be explored later and in relation to the formal teaching about compassion. It also seems important to point out that this finding, about the importance students place on relationship-building represents something of a disjuncture with the finding about communication skills, which only four (17%) out of twenty four students considered important. Clearly, professional relationships are developed through communication (I will pick this back up later) together with being caring and kind.

5.3.2 Caring and kindness

Nine (38%) students mentioned the words caring, kind or kindness in relation to compassion. This quotation shows one of the student's ideas about caring and kindness: '*compassion is treating someone with understanding and respect in a manner that you would want to be treated in that situation. This could include speaking in a kindly manner, handling someone with due consideration and care gently'* (24).

One student mentioned the notion of 'intelligent kindness' as needed for compassion: *'compassion is seeing somebody else in pain or in a bad or uncomfortable situation and wanting to be part of that situation and reduce the pain. It involves intelligent kindness, offering dignity, listening to somebody. It has many expressions'* (16). The concept of intelligent kindness, explored in chapter two, (2.3., p.28) is part of the DH's definition of compassion for midwives and nurses (2012, p.28).

As care is central to being a midwife and one of 'The Six Cs' (DH, 2012) it is not surprising some students thought this as necessary alongside compassion. Care is stated first in 'The Six Cs' list though each C is notably as important as the other. Care and midwifery practice are synonymous; throughout history women giving birth have always sought care from others. Prior to the 1902 *Midwives Act,* care for women in labour would have been provided by an untrained birth attendant (McIntosh, 2012). The Act saw midwifery begin to adhere to rules about '*The training, registration and regulation of midwives' and arguably the midwifery care that we are familiar with today started to evolve from this'* (McIntosh, 2012, p. 24).

The Act laid the foundations for practice and also for education with midwifery developing as a profession and those within it attaining a distinct identity (Royal College of Midwives [RCM], 2018). A central tenet of midwifery is the delivery of high quality maternity care for those experiencing normal pregnancy and birth and the midwife's input is needed at each stage (RCM, 2018). The achievement high quality care arguably starts with the students' pre-registration midwifery education. It is surprising, then, that the RCM's (2018) vision for midwifery *Education and professional development* contains no reference to compassion or how we should educate the future workforce to be compassionate. This perhaps shows a profession yet to develop a comprehensive research evidence base for educating its workforce about and for compassion.

It is notable though that the majority of students did not mention the terms caring and kindness in relation to compassion. It may be that they considered it unnecessary to identify these qualities because they thought they were self-evidently part of compassion. Furthermore, it suggests that students' starting points in developing an understanding about compassion on entry to the midwifery course are varied, which has implications for the teaching that follows.

5.3.3 Time

Six (25%) of the students considered that time was needed for compassion. This can be interpreted, at this early stage, as showing that some students were beginning to think about individualisation and how this sat in tension with the professional standards and use of time.

Clift and Steele (2015, p. 23) found the majority of healthcare professionals in their study specified that *'compassion should be given to patients, all of the time to be consistent'*. Others considered that compassion should be shown to distressed patients and at the right time. This shows, then, that for some healthcare professionals giving time is non-negotiable and this should be strived for, whilst others perhaps acknowledge that this is not always achievable and should be given when the service users need it. Either way it seems that experienced healthcare professionals understand that being compassionate requires time.

Eighteen students (75%) of the participants in phase one of my research did not mention time in their thinking about compassionate care. These students were yet to experience a practice placement, so had not observed the challenges that midwives face, including the many competing demands on their time. Such demands are evidenced by the maternity service's U.K. data. There were a total of 640,370 live births in 2019. Although this represented a 3.2% reduction on 2017 and a 9.9% decrease from the peak in 2012 (Office for National Statistics, 2020) there are other factors compounding the challenging demands on midwives' time. Such challenges include the number of midwives that at 55 years old become eligible to retire from the profession over the next few years (RCM, 2018). Also many midwifery job vacancies across the maternity services remain unfilled and women's care needs are becoming increasingly complex (RCM, 2018).

Over-extended and short-staffed services place further constraints upon midwives' time and this may affect the quality of compassionate care provided to

mothers and babies. Kirkham's (2015) view is that midwives' time costs money and in a market driven, highly standardised service like the NHS, compassionate care may be difficult to achieve. Kirkham's view seems at odds with the Maternity Service's aspiration of compassionate care, however, she has a valid point; when midwives do not have long conversations with women, their care is less time consuming. Taking less time to engage with women, for some, might be considered more desirable given the current constraints upon the NHS (Kirkham, 2015), though perhaps this view fails to follow the recommendations that care should be premised upon compassion. Compassionate care requires midwives to make themselves available, having the time to act upon what women are communicating to midwives.

5.3.4 Communication skills

Four out of the twenty four (17%) students considered that communication skills, including both speaking and listening, were needed for compassionate care. This finding is interesting when viewed alongside Clift and Steel's (2015) research which found that professionals in their study considered communication to be the most important attribute of compassion.

Therefore, at this early stage in their midwifery education the students had varying views on the importance of communication skills and different nuances in their understandings of compassion; most had not experienced - or had not recognised - any formal teaching about compassion in their previous education. It seems to me that these findings, perhaps, reveal that, at this early point, these students were at different stages in their thinking about how to develop a professional persona and identity – communication being one aspect of this, whereas others had a more inchoate idea about how they would learn.

These varying stages of student development accord with the notion of *'Learning as becoming'* and identity formation (Wenger (1998, p.5). Alongside the professional education Wenger (1998, p.151) emphasises that: *'...identity is a layering of events of participation and reification where experience and social interpretation inform each other'.* This suggests to me that theory and practice will each contribute to the students' development of a professional identity. In regards to communication some students had recognised that being compassionate required communication skills for example: '*I would engage with them, listen, communicate with them on a friendly basis and generally be a helpful confidant'* (11). This student arguably had already started developing along the trajectory of thinking about which communications were required in midwifery in relation to compassion; however, for others these issues would be picked-up and developed as their course progressed. Communication featured in year two and three modules so these the students would keep returning to it with the aim that they would develop a higher level of understanding and continue to link theory with practice. This pattern of development ideally progresses all through a professional career, well beyond the initial stages. This is neatly articulated by Wenger (1998, p. 155) as: '*the temporal dimension of identity is critical in negotiating our identities, dealing with specific situations and certain practices means that we become certain persons'*.

Here the student midwives that would develop a professional identity as a future midwife which included and required them being an able communicator (NMC, 2018, NMC, 2019).

In practice, communication would be a core attribute that these students would be assessed against in the future. Including, a set criteria of what effective verbal, and written communication skills are expected of midwives (NMC, 2019). The regulatory standards state that midwives must show: 'a *range of verbal and non-verbal communication methods and consider cultural sensitivities, to better understand and respond to people's personal and health needs*' (NMC, 2018 p. 9). This requirement suggests that communication needs to acknowledge some of the ideals associated with compassion, such as treating people as unique and considering their cultural needs. The midwife should also: 'u*se all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times*' (NMC, 2018 .19).

The advice and information given to women, both spoken and written, should be evidence-based and confidentiality should be maintained. In this it becomes clear that there is a close relationship between professionalism, compassion and treating people as an individual.

5.3.5 Treating people as individuals

Three out of twenty four students (13%) of students considered that treating people as individuals might be part of compassion. The low numbers mentioning this perhaps show that most students were yet to consider the importance of this idea for developing as a compassionate professional. Moreover, they had yet to reify compassion and in a midwifery context.

This student had already begun to think along these lines as she described her pre-course experiences: '*I understood that her experience was completely*

unique to her and made sure she felt understood. I also cried alongside her' (14).

Teaching students that women must be treated as individuals is important and accords with the findings of a number of researchers who have identified the importance that women place on having midwives who treat them in this way (Fraser, 1999, Walsh, 1999). Fraser argued that women's perceptions of childbirth must be included in the midwifery curriculum. The aim of her study in 1999 was to explore what women wanted and expected from a midwife. Women considered that individualised care was important to them; they preferred to be supported by only a few midwives who knew them and their situation well. Fraser's participants also valued student midwives' involvement in their care, as this offered a continuity of carer. More recently, Kirkham (2015) has argued that compassion is largely about response to individual needs and is truly achieved when midwifery care meets the needs of the woman. In my findings, a number of students said that a lack of knowledge about mental health illness had prevented them from being compassionate in the past (8; 17; 9; 6; 1). This can be regarded as another aspect of being treated as an individual. The importance of this kind of understanding seemed to be increased for some students when they themselves had suffered with mental health illness. Once the students had recovered, their own personal experience of the illness apparently assisted them in being able to empathise with those suffering with mental health illnesses. This finding resonates with Noddings' point (2003, p. 30) *'How would I feel in their shoes?'* and also suggests that an individual's compassionate response in relation to illness may be enhanced when they can empathise as a result of their own experiences.

As only some student midwives had, themselves, experienced mental health illness and so developed their personal knowledge, this finding might suggest that students need to be taught about the illnesses women may face before, during and after birth as key to supporting them in being able to put compassion into action.

5.3.6 Role Modelling

Three out of twenty four students (13%) of students considered that an understanding of compassion might be enhanced by role modelling others. One student commented: *'I think the fundamentals of what compassion means can be taught and role modelled by other people'* (14). Role models could be those whose behaviours are compassionate and those whose are not*: 'this can be learnt from someone who shows you a great deal of compassion who you aspire to be like or from someone who shows no compassion and you vow to never treat someone like that...'* (17).The significance of this finding is that it suggests some students were thinking about how they may learn to be compassionate in their professional lives. This highlights the importance of mentors' behaviours. This idea is in keeping with Wear and Zarconi's (2007) study which compared medical students' experiences of mentors who were kind, altruistic and compassionate to patients with those who did not display these values. Both sets of mentors informed the medical students' understandings of compassion. Other scholars have also acknowledged the importance of role modelling in increasing understanding of compassion.

Bray et al., (2014) go so far as to propose that undergraduate nursing curricula should include the signs and symptoms of uncompassionate behaviours. This

further supports the importance of formally teaching student midwives about the ideas associated with compassion (Pearson, 2018).

This section has sought to present and explore the students' responses at the start of their midwifery education and before they had been formally taught about compassion during the module. The students' responses were largely found to be premised upon their pre-course life. Therefore, this forms part one of the three interrelated educational phases that influence understanding about and for compassion. The next section considers how the formal teaching about compassion, during the module that they undertook, had influenced the students' understanding of the value.

5.4 Formal teaching about compassion

This section focuses upon the findings from phase two and three of the research and the responses from years one, two and three. Additionally, some of the pertinent findings are included from the three focus groups. The emerging sub-themes were: empathy and sympathy, communication skills, role modelling and barriers to compassion. Given that the latter two themes also emerged in phase three, these are combined with and discussed in the final section of this chapter (5.6, p. 153).

Renegotiating the meaning of compassion and building upon students' pre-course life experiences began with the formal teaching about and for compassion during the taught module. The taught content, pedagogies and assessment of the formal teaching that students had received have been briefly outlined in chapter one (1.3, p. 21). Furthermore, the compassion module is detailed in Appendix One (p.238) and adds context to this section.

5.4.1 Empathy and sympathy

Empathy was mentioned by six (27%) out of twenty two students in year one; four (13%) out of thirty students in year two and in year three it was eight students (28%) out of twenty nine students. For me, this highlighted that compassion needs to be learned recursively to deepen the students' understanding. Those recalling empathy from the module content explained how it had been useful to their understanding. One student said that: '*I think it developed my empathy a lot more because I was able to sort of say well, why do you think she acts that way? You know it could be causing that behaviour'* (=*2). Another said: '*I don't think that my compassion has changed. I think that it's my level of empathy, so my ability to be empathetic and think about why that person is that way, or why they're acting that way'* (=* 3).

This student described learning the differences between sympathy, compassion and empathy and said: '*I think I thought compassion, sympathy, empathy, although I knew they were all different-I would have all-put them all in the same basket and I just-I would have used them interchangeably'* (=*3).

Sympathy was mentioned by five (23%) out of twenty two students in year one; Four (13%) out of thirty students year two and two (7%) out of twenty nine students in year three. This finding showed that the association between compassion and sympathy, seemingly, decreased as students progressed through their midwifery course. Whilst Snow (1991, p. 196) suggests that sympathy is needed for compassion, student midwives had been taught and socialised into the philosophy that pregnancy and birth for many women is a normal life event and not illness. Therefore, some midwifery students may not have linked sympathy with compassion as they progressed through their education. So actually, although by default, students not linking sympathy to

compassion as they progressed through their course showed that learning had taken place. This is evidenced by year three students who reported, in their view that the connection was not strong between sympathy and compassion.

Observed from the student's concepts of empathy and sympathy was the application to their relationships and interactions. Additionally, these quotations show that they had become reflective about their midwifery practice. Although, the principles of reflection were taught in the module, no students explicitly mentioned this and its relationship to becoming a compassionate midwife. However, it was obvious that some students had begun the process of internally examining and exploring issues of concern, triggered by experience, in ways which 'create(d) and clarifie(d) meaning in terms of self, and which results in a changed conceptual concept' (Johns, 2017).

Reflecting upon her experiences of compassion, a year three student described her experiences as variable. She said: *'I've come away from a few situations thinking, oh I was rubbish in that, or maybe that will gear me up in future in that situation, and you know you almost see it differently don't you? Because you feel kind of helpless and what more could I have done?*' (=+3).

This accords with John's (2017) notion that reflection is initiated when uncomfortable emotions and thoughts arise from an incident where a lack of knowledge prevents an individual from making sense of a situation. The above quotation echoed this idea. Analysis of care and interactions by students requires them to draw upon their feelings and knowledge, in an attempt to improve their professional practice. Useful to the understanding about

compassion, then, is to facilitate the reflection on care interactions, especially for those who cannot draw upon their own experiences of midwifery care, pregnancy and birth.

It is likely that students at the same stage in their midwifery course, were at different points of thinking about empathy and sympathy in relation to compassion. It seems pertinent, then, that students are taught the skill of reflection and for educators to evaluate how meaningful this has been for the students. The quotation below shows that this student could not fully recall covering the skills needed for reflection: ' *I was thinking we had some stuff on- we all have to do reflections and stuff in practice- but whether reflection-maybe a bit more focused-I don't remember that actually being in the module, maybe I am wrong*' (=#2).

This evidence supports the notion that although the students had been taught the theory associated with reflection, this needed to be more meaningful and perhaps related to analysis of critical incidents in practice. This might have helped the student's recall of the content about reflection covered during the module. Alongside reflection students had been taught the importance of communication skills in being and acting compassionately.

5.4.2 Communication skills

The importance of the communication skills needed for being compassionate was acknowledged most by the year one students, as well as a few in year two and three. The quotations that follow, serve to highlight how it had helped some students' understanding. One student said that learning about compassion heightened their awareness of the need for: '*communication in compassion'* (YR1; S10). Another said: *'always listen and be present with the woman (YR1: S1).* Given that this student had only been in practice for six weeks, perhaps shows that they had drawn upon their own experiences to inform their thinking about compassion. This student said: *'I was more aware of my bodily actions and what I was saying. It helped with communication skills'* (YR1; S1). This refers to the importance of the non-verbal ideas around communication taught during the module. This student said of the module content that it had: '*made me stop, and think and listen before talking or acting'* (YR1; S3).

It was disappointing more students (in particular those in years two and three) did not mention that communication is needed for compassion, since this was a major emphasis of what they had been taught.

However, the fact that they failed to mention this does not mean these students were not able communicators. On the contrary, students in years two and three would have undertaken and passed a number of summative practice assessments, and fundamental to these would have been communication skills (NMC, 2009, 2019). Therefore, I interpret the student's quotation below as implicitly referring to communication as 'necessary skills': '*it prepared me with the necessary skills to provide compassionate care to every woman regardless of their situation*' (YR3; S16).

Likewise, another student remarked that: '*it made me more aware of my behaviour whilst in practice and to look out for how I actively implemented compassion into my practice*' (YR2; S9).

The ideas of Taylor, Hodgson et al., (2017) are useful in analysing the quotation above. Taylor argues that compassion requires us to recognise, connect, a humanistic response and finally an action (Taylor et al., 2017). The comment suggested that this student had begun to *recognise* their own behaviour by being 'more aware'. The *connection to* compassion was hinted at as they said 'whilst in practice'. It may be interpreted that Taylor's idea of a *humanistic response* was in the manner that the student described; *'to look out for how'* and finally 'actively implementing compassion' perhaps shows the student considering they had put compassion into *action* and their 'practice'.

This speaks to Wenger's point (1998, p.66) that meaning (here compassion) is premised on the idea that: 'p*articipation requires reification both require and enable each other. On the one hand, it takes our participation to produce, interpret, and use reification; so there is no reification without participation'*. In other words students' experiences in both theory and practice will work together in helping students make compassion meaningful. A reflection on the formal teaching students had received, in relation to the findings, now follows.

5.5 Reflecting on the formal teaching in relation to the findings

5.5.1 The aims and intended outcomes of the compassion module

The aim of the compassion module was to examine how professional and personal attributes support the development of emotionally intelligent, resilient midwives in giving compassionate and holistic evidence-based care (Pearson, 2018 p. 262). By the end of the module the learning outcomes that students should have achieved were to:

1. Recognise the personal attributes that support the development of emotional intelligence and resilience and apply this knowledge to midwifery practice.
2. Describe how a knowledge of professional attributes can support the delivery of holistic compassionate midwifery care.
3. Identify how professional regulation impacts on personal and professional behaviours (Pearson, 2018 p. 262).

These outcomes were designed to lay the foundations of understanding about compassion for students. So, the command words (recognise, identify, describe) followed the Blooms' revised taxonomy hierarchy (Anderson and Krathwohl, 2001).The six levels of the hierarchy includes: remember; understand; apply; analyse; evaluate and create. Using Bloom's revised taxonomy to underpin the learning outcomes within curricula is designed to promote students' progressive thinking and learning (Anderson and Krathwohl, 2001). Moreover, the command words used for the learning outcomes in each year of a course demanded more of the students thinking and application to the topic being studied. This aimed to scaffold students' progression in learning across the course, for example, at a later stage they were expected to be able to analyse and evaluate their theoretical, practical, knowledge and skills in relation to the topic being studied.

Learning outcome one stated that students should be able to apply their knowledge (gained from the module) to midwifery practice. The module ran for six weeks and ended prior to students attending their practice placement. Therefore, it is unknown whether students were able to apply their knowledge of compassion to midwifery practice. Therefore, this raises implications about the order of the theory and practice. Perhaps, to achieve learning outcome one a more suitable approach would have been to interleave (Kang, 2016) theory and practice. This would result in students being able to reflect upon their own understanding of compassion and apply this knowledge to the clinical setting. This would mean that theory informs practice and vice versa. Starting with theory, the students had alternate blocks of theory and practice. There may be potential benefits to reconsidering this model (Kang, 2016). For example, the interleaving of theory and practice in the same week. This is said to improve both memory and knowledge transfer from theory to practice (Kang, 2016). However, the spacing of theory and practice was implemented in response to students' past course evaluations collated from a number of years 2010-2014. These evaluations repeatedly said that students wanted to concentrate on either theory or practice, not both at the same time. What this shows is that although the pattern of theory and practice was in response to student evaluations of teaching, this is perhaps not always the most conducive to learning and in the case of compassion being able to apply the practice to theory and vice versa.

The intention for the midwifery curriculum, when it was designed had been to make use of Bruner's (1962, 1979) Spiral Curriculum so that students were able to reinforce their learning by revisiting core concepts and building on prior

understanding to increase complexity. This would mean as a concept compassion could be learned recursively (Scott, 2002); in years two and three students should be applying their theoretical understanding of compassion to their formal and informal practical situations. This suggestion resonates with Bruner's (1962, 1979) constructivist theory and aligns to my personal perspectives about learning.

Reflecting upon the module for the purposes of this research project, though, it became clear to me that we were not, in fact, following a Spiral Curriculum design as compassion is not revisited in years two and three. Importantly, the lack of education about compassion in year two had not gone unnoticed by this student: *'I want compassion all the way through, rather than it just being a starting point. I think it needs to be all the way through so it's like a vein running all the way through'* (=*2).

Not building in these key return points to compassion that deepen and strengthen students' learning in years two and three is considered a major curriculum design flaw. Examining this shortfall, has made me reflect upon the fact that, as midwives, in the main our expertise is in clinical practice and less so in educational curriculum design and pedagogy. For me this shows the value of continued professional development, which is a key feature of clinical practice however, I think there is less emphasis on our educational development as educators. As educators we are supporting students in both theory and practice, therefore each needs equal consideration when developing staff.

Another comment from a student in my sample highlighted considerations for future midwifery curriculum: *'how compassion runs through the rest of the theory side with the university, I have questioned that on a few modules because obviously we are on the new curriculum that's the spiral curriculum and there has been the odd module, where I've thought, that's not very compassionate'* (=+2).

This student's observation has prompted me to reflect on the issues to consider during future curriculum and module development. The workload of those involved in curriculum/module design can and often does dictate the time that can be devoted to looking at each module and the curriculum as a whole. Giving protected time for this vital step would ensure that the intended design has been followed throughout. Whilst the compassion module was taught as a discrete unit, my suggestion is that in future iterations of the curriculum, the formal teaching and study of compassion should be revisited in years two and three. Additionally, that the key concepts are woven into core modules. The addition of a year two and three module about compassion would support students to deepen their learning as they move backwards and forward between theory and practice.

By re-designing the module with this in mind, it allows me to consider that a core part of teaching compassion is ensuring that individuals learn about the process by applying their socially constructed and cultural understanding.
As Bruner proposes: 'L*et the education process be life itself as fully as we can make it'* (Bruner, 1962, 1979 p. 126).

5.6 Learning about and practising being compassionate in Clinical practice

This final section focuses upon the students' practice experiences and their associated learning. Similar to the previous two sections, Wenger's (1998) Communities of Practice both frames and is thought useful to analyse the students' findings from their practice experiences about compassion.

5.6.1 Contextualising practice learning in midwifery education

Clinical practice and theory coexist in midwifery education, fitting neatly with Lave and Wenger's (1991, p. 51) idea that knowledge acquisition '*has no beginning or end'.* Instead, this learning continuum includes our relationships; interactions with others and the context we find ourselves in. Shared learning between the university and practice setting are often in different locations. Therefore, midwifery educators are not involved in most of the students' practice learning. I am not presenting this as a problem, as the clinical midwives supporting student learning will have undertaken education to prepare them for this role (NMC, 2018). However, it is not clear how and what midwifery students may learn about compassion in practice, as there are few current literatures highlighting this.

Taking Wenger's (1998) idea of reification suggests that practice is an integral part of '*learning as experience' as* individuals seek to make their own *'meaning* 'of the situations they are in. As shown earlier in the chapter, this starts with students' own life experiences and is then built upon during the formal teaching.

The practice placements will allow students to begin to reify compassion in a midwifery context. This will be both varied and individual to each student as the interactions experienced by student midwives with women and their families are very diverse. However, prior to eliciting the sample group's experiences, it was unclear what examples of compassion students might experience in practice. It would probably be helpful to the teaching process if such experiences could be elicited. The ideas germane to the teaching process are briefly presented in this section. The final chapter refines and expands these perspectives as informed by the findings and with the intention of offering something not previously explored in midwifery.

It was anticipated that midwifery practice may help students to make sense of their feelings and emotions in relation to compassion. This students' responses during phase three showed how their '*understanding about compassion'* had changed as a result of the formal study and practice placements.
The student's perspectives highlighted this and they reported that: '*I found it helpful- I remember literally thinking back to the compassion lectures after a few weeks in community and I remember thinking back to the lectures where they said, "you will face that in practice and you need to be compassionate to yourself", and almost like practise resilience when you get home from placement, because I remember coming home and like trying to shake off the day and like be compassionate to myself and look after myself.* (=#3).
This quotation highlighted some considerations for the future teaching about compassion and in relation to the feelings and emotions that may be experienced in clinical practice. It suggests to me that the ideals taught during theory for some students, may be at odds with their practice realities.

Furthermore, consideration needs to be given about how each of these aspects may be reconciled to support students' in learning about compassion. What strikes me as interesting about this quotation is that the student's first *'meaning'* about compassion was in relation to herself. The literatures on professional learning are useful to consider to better understand why this was. It is suggested that when we first start to inhabit professional roles we do so self-consciously with concerns about our own performance (Beijaard, Meijer et al., 2004). Only as we develop competence and confidence in the role, emphasis may move away from our own performance apprehensions (Beijaard, et al., 2004). Wenger (1998, p.5) sees *'learning as becoming'* and developing a professional identity can therefore only really be '*worked out in practice'* (p. 151) and through participating in a CoP.

These ideas combined with my findings, suggests that the future teaching about compassion needs to focus on the students' individual experiences and thought given as to how they may draw meaning and subsequently learning from the practice involvement. Using their real life stories about midwifery practice may facilitate reflection about students' values and beliefs (Gilkison and Giddings et al., 2016 p. 19). Stories about compassion in practice may be useful in supporting students' learning about compassion when explored during theory in a formal and structured way. This means that theory and practice may be brought together in a more meaningful way. Having studied compassion followed by practice the students' quotations below shows there had been a change to their understanding about compassion.

It was considered: *'to be more complicated than previously thought'* (=/1). Furthermore, studying the compassion module followed by the practice experiences for this student had: *'introduced different ideas about compassion and it is not simple, it includes many different ideas'* (=/1).
Educating students about compassion is thought complicated as it requires learners to engage in '*thinking and feeling that may be conscious and unconscious'* (Walker et al., 2016, p. 23). To some extent this point is illustrated by the student below as she described that during her placement: *'all of the midwives cried in front of me at some point*' (=/3).

Emotions evoked by this type of interaction may therefore, need nurturing during students' education to support their understanding about compassion. Students learn from their experiences, unconsciously, when they are in familiar situations, however on a conscious level when situations are either unexpected or unfamiliar (Walker et al., 2016) like the emotionally charged situations that students might find themselves in midwifery practice. This has further significance as some scholars believe that compassion may be suppressed amongst healthcare students if they are encouraged to hide their feelings (Walker and Mann, 2016). In turn, this may leave some students struggling to express themselves under what is described as a '*professional armour'* (Walker and Mann, 2016 p.188).

This may be problematic for being compassionate, as arguably it requires a connection between the midwife and woman. Therefore, this highlights the importance that learning about compassion requires students to see their own meaning of the value in their own professional practice and is therefore part of

their identity development (Wenger, 1998). This student had an interesting idea about the reification of compassion, practice and developing their identity: *'can you learn compassion? I suppose in a way that you can, you've learnt how to deal with situations that you might not have been able to deal with before'* (=/1). The progression in thinking about compassion was shown by this student: *'I initially thought that compassion cannot be taught'* (=/2). However, studying about the ideas associated with compassion followed by working in practice had changed her opinion and she described learning: *'the tricks and tips' learned during the module helped me to be compassionate or at least be more mindful of my actions'* (=/2).

The 'tricks or tips' learned during the compassion module, perhaps hint at this student beginning to develop her understanding about compassion. This started with her initial stance that compassion could not be taught. The practice placements meant that the taught theories and concepts, combined with: '*learning as experience'* and *'learning as doing'* (Wenger, 1998, p.5) had facilitated a shift in her initial thinking. In combination, theory and practice seemingly had worked together to support *'learning as becoming'* and in starting to develop a professional identity. Midwifery education is considered as the starting point for the professional growth and socialisation of midwives. Such development of a professional identity as a midwife is considered as twofold. On the one hand professional identity development requires the knowledge acquisition and on the other adopting and internalising the professional values, beliefs and attitudes (NMC, 2009; 2019) required by a midwife. Wenger (1998, p.149) suggests that there is a '*profound connection between identity and practice*'. This accords with learning in a CoP as Wenger (1998, p. 149) proposes

that a '*learning trajectory defines who we are by where we have been and where we are going'*.

This suggests to me that the students' life experiences, formal teaching about compassion and the practice placements therefore assisted the students to start forming their professional identity.
Moreover, identity is a '*negotiated experience'*. (Wenger, 1998 P.149).
Identity, 'is a layering of events of participation and reification by which our experiences and its social interpretation inform each other' (Wenger, 1998 P.151). Such notions posited by Wenger have resonance with the emerging sub-theme of role modelling.

5.6.2 Role-modelling

Role modelling first emerged in phase one of the research, showing that the students thought it was important to inform their learning about compassion. The interactions with their mentors as role models had according to some students impacted their experiences of compassion. When some students told their mentors about formally studying about compassion and it was their first module there were mentors who thought this was odd. Students considered the mentors who did not see value in learning about compassion as non-compassionate individuals.

Another student said that completion of the module had highlighted what she perceived as compassion not being valued. This led her to think about some mentors that she had encountered: *'you need to go and do that module'* (=#2).

So, as with the personal stories of when some students (in their pre-midwifery course life) had described both their compassionate and non-compassionate selves. The practice experiences and their mentors as role models had led students to think of 'what to do' and 'what not to do' regarding compassionate behaviours during their practice placements. These students' quotations lead me to think that these could be useful for the future and 'teachable moments'. Furthermore, that real learning can take place if these experiences had been followed-up and explored alongside the concepts taught during the compassion module known to be helpful when being compassionate.

A year one student made an interesting observation in practice saying that:

'I did see compassion, but it was more in terms of when there'd been like a bereavement or something. I didn't see it as much as I thought I would in everyday interactions' (=#1).

This student's comment suggest that another aspect to the reification of compassion is twofold. Firstly, that there is 'everyday' compassion that should underpin all midwifery care; compared with compassion reserved for times when dealing with bereavement described by the student above. Useful to the analysis here is a consideration of the education literatures. The creativity literatures offers a useful analogy to the discussion here namely, Big-C-Creativity and little-c-creativity (Kaufman and Beghetto, 2009). Big-C-Creativity is thought useful for monumental occasions (like singing in an opera) and little-c-creativity used by people in their everyday lives (Kaufman and Beghetto, 2009). If we use the 'Big C' and 'little-c' analogy here; the student's quotation suggests that her mentor had reserved the 'Big C' compassion for 'bereavement'. Following this idea

means that everyday interactions around compassion may include 'little- c'. This student's experiences were not seeing either Big or little c compassion in everyday midwifery care. As midwifery care should be premised upon compassion, the role of the teaching should help students to consider that there will be occasions for compassion to take on 'Big C' importance like when women are experiencing 'difficult situations' such as loss. However, little c compassion needs to be part of all midwifery interactions and care delivery given its renewed focus and calls to action (Francis, 2013).

The intention following the compassion module had been for the students to role model compassionate behaviours by their mentors in practice. My findings have shown that this was not true for all students. Nonetheless, despite, the students' perspectives it had informed the: *'learning as experience' (Wenger, 1998 p.5)*. It helped them to know the future midwife they aspired to be and so had perhaps also informed their *'learning as becoming'.* Wenger (1998, p.8) echoes this point suggesting that: 'e*ven failing to learn what is expected in a given situation involves learning something else instead'*. Even so, this has implications for the future teaching about compassion. Non-compassionate role models are at odds with the aspiration that students should be socialised into a healthcare environment that values compassion.

Compassion and '*learning as experience'* (Wenger, 1998 p.5) may sit in tension with the taught theoretical ideals when compared with the practice realties of a financially challenged National Health Service (NHS) (Dunn, McKenna et al., 2016). This is also evidenced by Francis (2013) who suggested that some NHS learning

environments are not always conducive as staffing and financial targets often take precedence over student learning. This notion is further supported by Curtis et al., (2012) who report that students' socialisation into compassionate practice should take place in environments where it is given importance. My personal stance is that whilst compassion is frequently cited as an aspiration of healthcare (NMC, 2018 Francis, 2013, DH, 2012, DH, 2016); unfortunately this has not been accompanied with any tangible evidence of how this is currently being achieved, rendering it largely rhetoric (Pearson, 2018). More importantly, as students learn through experience this may mean that some students will observe non-compassionate role models and see this as the norm (Francis, 2013). Therefore, the teaching about compassion can counter such practice influences. Wenger (1998, p.73) explains that cultures within a CoP starts with a '*mutual engagement'* of its participants. This is complex in relation to compassion and a '*coherence that transforms mutual engagement into a community of practice requires work*' (Wenger 1998 p. 74).

This 'work' started during the compassion module as students were taught how to consider cultures and sub-culture formation. Furthermore, students were taught to analyse the norms and practices that were considered to be healthy and working well (Amess and Tindall-Biscoe, 2014). When students join the midwifery profession their *'learning as belonging'* (Wenger, 1998 p.5) begins and will involve them understanding the cultures they become immersed in. It is important that both the realities and ideals of compassionate care are explored during the teaching.to help students better understand the individual behaviours of midwives that may support or inhibit compassionate care.

Some students had already started to think how and why compassion was either present or lacking in some of their practice interactions. The student's experiences of compassion were variable, with midwives who they themselves wanted to emulate and others that were not compassionate at all. Both types of exposure to compassion or lack of it had informed the students' learning in some way. Knowledge of compassion had led students to consider its absence was due to their mentors being stressed because of staff shortages and resulting in excessive caseloads of women to care for. Such conclusions by students had been informed from the compassion module where these types of realities had been explored. However, despite some mentors being 'busy' and having large workloads some third year students also observed compassionate individuals. The students described these midwives were compassionate to them, colleagues and women. It was these midwives that the sample group described as 'good role' models and who they aspired to be like. When asked why the students thought that some midwives were compassionate and others not, they described them as being 'genuinely interested in the woman and her situation' to these midwives it was more than a job. Others did not conform to the prescriptive time slots allocated to women by their organisation and some students reported that this helped towards compassionate care being given. The students also considered midwives who placed the women's needs before the targets set by the organisation were compassionate individuals.

Furthermore, Wenger (1998, p.79) suggests that the CoP will develop as part of a larger context with the '*resources and constraints of their situation*'. My findings show that some of the midwives the students described, had made a

choice to be compassionate and others not. In a CoP members have to decide what they: *'attempt, neglect, or refuse to make sense of.....and to seek new meanings'* (Wenger, 1998, p. 81).

The implication of some mentors being compassionate and others not, would be useful to explore with students during the formal teaching about the value. There is a recognised phenomenon that healthcare professionals may be suffering from called: *'compassion fatigue'* (Neff, 2015, p. 192). This term is described as '*exhaustion and burnout experienced from exposure to the continued care of traumatised patients'* (Neff, 2015, p. 192). It often occurs amongst midwives, who are most empathic and sensitive as they feel the woman's suffering more deeply. In time, this can take its toll on an individual's ability to be compassionate (Neff, 2015, p.192). The work of the professional education is to teach student midwives about being compassionate to 'self' (Beaumont, Durkin et al., 2015, p. 239). In turn this may help students to prepare for the emotional demands of practice. The student below knew the importance of being compassionate to herself (Neff, 2011) acknowledging the need to: *'...be compassionate to yourself before you can be it, do it, to anyone else'* (=+3). Some mentors supporting students' learning may have been experiencing compassion fatigue and even complete burnout, this may have impacted students' learning as they witness disillusioned, overworked midwives (Kirkham, 2015).

Burnout is a well-recognised phenomena in healthcare and described as a physical, emotional exhaustion arising from working in a constantly stressful environment (Hunter and Warren, 2015). Acknowledging these practice difficulties the students' education about compassion had included self-compassion, burnout and the strategies useful in supporting and managing the more negative aspects of midwifery (Ewers, 2015). The following quotation showed how this student had found knowing about the taught concepts useful in practice and she said: *'you could get burnt-out. I think that's what it taught me like resilience'* (=#3).

From this quotation it seems that this student during the compassion module had learned something of the need for resilience to support her being able to give compassionate care. The students had been introduced to resilience, which is described as the '*relative resistance to adversity'* (Hunter and Warren, 2014 p. 927). Resilience, has, like, compassion been acknowledged as an important requisite for health professionals' development needs (DH, 2016). There are a number of benefits of being resilient including: the ability to manage the inevitable ups and downs of the emotions and stress that students will face in practice. Hunter and Warren's (2014) exploratory descriptive study focused upon resilience in midwifery and concluded that although a complex phenomenon, educating midwives about it is key to an individual's professional development. Student midwives were introduced to the idea of resilience during the compassion module in the hope that it would help them when faced with adverse and stressful clinical situations.

Resilience can be learned and developed and students were taught about the following*: 'reactive and proactive strategies'* (Hunter and Warren, 2015 p.113) each considered helpful. The aspiration was that teaching students about reactive strategies, would initiate their thinking about coping strategies. These are highly beneficial for midwives who work in an often very stressful environments. For example, students were introduced to the idea of music and exercise as just some examples of positive mood enhancers (Hunter and Warren, 2015). More broadly, students were encouraged to maintain a course-life balance and access the university's social societies with the belief that they would have interests alongside their course. Hunter and Warren, (2015) describe proactive strategies are needed to build resilience. During the compassion module teaching about resilience took the form of a lead lecture, exploring the 'critical incidents' students may find themselves in practice. However, taking Wenger's (1998) point about reification in relation to resilience, future teaching should be approached differently. At the initial starting point students could have been asked to discuss a time in their pre-course life when they had been or needed to be resilient and what they had learned from this. The analysis of students' ideas about resilience could be framed around Wenger's (1998, p.50); notion of '*learning as experience*' and *'learning as doing'* as students consider how their experience of resilience is useful for them and future midwifery practice.

Revisiting resilience in years two and three of their midwifery education would support students to reflect upon the 'critical incidents' experienced during clinical practice and so help them to build and develop personal strategies to deal with these. As some difficult matters may arise during these discussions small group

teaching would be preferable so that students requiring additional support to deal with the issues may be identified. In future, these strategies may support them in turn to be compassionate role- models to others (Schiraldi, 2017 p. 2). Alongside role modelling sometimes impacting students' experiences of compassion, the findings also revealed other barriers to compassionate care.

5.6.3 Barriers to compassion

Students in phase one of the research had not mentioned any potential barriers to giving compassionate care in practice. This data had been collected prior to their first placement and so there was a lack of *'learning by experience'.* Such learning, had, however informed students in year one (after their practice placement) and those in years two and three.

All year groups described some kind of barrier in practice, which served to impede compassion. These were interesting comments as there were differences across the three year groups. For example, a year one, phase two student thought that the lack of compassion lay with the *individual midwife* (YR1;S21) a year two student's comments were about the *maternity ward's* pressures (YR2;S22) and a year three student considered that when compassion was lacking it was the *institution's* (YR3;S9) fault. Lack of compassion being down to an individual has some resonance with Clift and Steele's (2015) research. Their participants also suggested that personal characteristics such as those who do not value compassion can hinder compassion. Individuals '*hold the key to transformation... that has a real effects on people's lives'* (Wenger, 1998 p. 85). To some extent, where compassion is concerned, the macro structures in healthcare are much more difficult to change and control than individuals. As a

midwife, I have always believed that we can make a real difference to women's experiences of care by being compassionate to them. Therefore, individuals can and do impact whether compassionate care is given or not.

A year two student suggested that the barriers to compassion existed at the midwifery ward level and again, this accords with Clift and Steele's participants who said that obstacles such as the physical and social environment can prevent compassionate care. Wenger suggests that it is the CoP who have to work to alleviate and overcome barriers through: '*mutual accountability' by deciding what is important to them'* (Wenger, 1998 p. 81). For example one student described a mentor had given care to a woman on the ward and thought that the interaction was lacking *compassion* (=*3). Another described that during an interaction with a woman the mentor had: *'turned toward the computer'* (=*1). The student went onto to describe, for her, this showed a lack of compassion. Moreover, that it would prevent the woman feeling connected with and perhaps unable to confide in the midwife.

These students' quotations show that learning takes place in this practice interface and facilitates what Wenger describes as: '*producing meaning of the interaction'* (1998, p. 203). Arguably, for these students, such experiences had enhanced their learning about compassion by seeing its absence in some care situations. In future by focussing upon some of these insights and small moments in class – through discussion or role play – might help embed students' learning and perhaps give life to the idea of everyday-little-c- compassion.

Finally, attempting to make sense of the student's comment that the *'institution'* (YR3; S9) posed a barrier to compassion, Wenger's notion (1998, p. 79) that a CoP develops in a larger institutional context with specific resources and constraints may be useful to consider. He goes onto suggest that the institution can: '*shape conditions outside the control of its members*' (Wenger, 1998, p.79). It is up to the CoP to overcome barriers in the environment and to make it their '*enterprise*' (Wenger (1998, p. 79). Therefore, compassion has to be important to all members of a CoP, that is, if the barriers preventing it are to be overcome, including the individual; ward and institutional challenges (RCM, 2016). The challenges faced by the maternity services are multi-factorial and these may in turn impact student learning in practice. During care delivery, short staffing levels and high numbers of women to care for leads to pressures on midwives' time, which is one requisite of giving compassionate care (Kirkham, 2015). Such pressures has seen many midwives leave the profession, as they could not give the compassionate care they wanted to (RCM, 2016).

Therefore, this may have an impact upon student learning as they may often witness disillusioned, overworked midwives (Kirkham, 2015). By teaching those who are newly entering the midwifery profession about the importance of compassion, has a potential to improve the individual, ward level and institutional appreciation for compassionate care and kindness in the future.

5.6.4 Caring and kindness

Though not synonymous terms, caring and kindness are used in the generic lexicon of midwifery practice. Kindness and intelligent kindness have already been presented as key to giving compassionate care in chapter two. Care and caring are interrelated constructs. Care in midwifery may be summarised as midwives responding to women's needs during pregnancy, labour and the postnatal period. Caring is described in the Oxford English Dictionary (Thompson 1995, p.198) as the notion of, *'looking after'*. Furthermore, the word '*kind'* can also be seen within the OED definition of caring. Such references to the word kind alongside caring may suggest why, some of the students considered that caring and kindness were important for compassion. The concept of caring, requires some form of action by the midwife. This fits quite neatly with: *'learning as doing'* (Wenger, 1998, p.5) and possibly, caring and kindness are only fully understood when students are participating in the hands-on midwifery care. The findings highlight this in the following way: the number of students who considered that caring and kindness were needed for compassion increased according to their length of time spent in practice. This adds further weight to the importance of *'learning as doing'* in practice.

In year one, the number of students reporting caring and kindness needed for compassion were, nine (41%) out of twenty two students. In year two it was seventeen (57%) out of thirty students and in year three it was eighteen (62%) out of twenty nine students. However, unless caring and kindness are valued and their relationship to compassion understood, then healthcare professionals may not see its importance (Procter, Wallbank et al., 2013). This is further emphasised by the above findings which, show that not all students considered

caring and kindness relevant to being compassionate. It would have been illuminating to better understand why this was the case.

This lack of a reference to caring and kindness needed for compassionate care by some students perhaps reflects the ongoing concern for the midwifery profession including: suboptimal and non-compassionate care if measured against local and national clinical guidance (Kirkup, 2015). The examination, by Kirkup (2015) reviewed the catastrophic maternity care failings, leading to a number of maternal and neonatal deaths at the Morecombe Bay's NHS Trust. It was revealed that a lack of competent and clinical, care together with a breakdown in the working relationships between the midwives, obstetricians and paediatricians contributed to these failings (Kirkup, 2015). Moreover, Kirkup (2015), highlighted that some midwives pursued the enterprise of a 'normal birth' at all costs, resulting in a number of preventable deaths to women and babies. The scope of practice is clear and where women's pregnancies and births are without complication midwives can provide care autonomously. However, midwives also need to be able to diagnose deviations from the norm and refer on appropriately (NMC, 2019). As seen in the Kirkup Report, these midwives failed to meet their scope of practice. Wenger's (1998) idea that members of a CoP have to negotiate what is important to all members, is for the CoP to decide:'....*what matters and what does not, what to display and what to withhold...'* (Wenger, 1998, p. 81). It appears that the focus here was the pursuit of 'normal birth' at all costs (Kirkup, 2015) and so in this example CoP can be detrimental to student learning.

Therefore, Wenger's idea, that CoP support learning, is at odds where students are seeing and participating in sub-optimal practices, seen as the norm and shown to have dire consequences. Wenger, himself acknowledges that belonging to a CoP can be both a: *'strength and a weakness'* (Wenger, 1998 p. 85). The student's quotation below suggests that she was prepared for both the positives and negatives in the placement saying: *'I remember us being told not to have rose-tinted glasses, um, which is probably useful'* (=#3).

This quotation may also reflect that the students had been asked to read the Kirkup Report (2015). The aim of this was to introduce the idea that midwifery care needs to be both competent and compassionate. Using a tangible narrative of where caring and kindness have gone awry, as evidenced in the Kirkup Report aimed to initiate students' thinking about the midwifery cultures they may find themselves in. Importantly, for the students to understand what is acceptable as a midwifery norm and what is not?

In light of my findings, which have shown not all students acknowledged caring and kindness are needed for compassion; requires analysis of how the professional education may address this deficit. Additionally, this raises questions for me, of how students can make caring and kindness their own, as participants within the community of midwives. There are also important cultural questions about individual and group identity. Useful to this exploration, is Wenger's idea that a CoP must have a *'shared repertoire', 'not in and of themselves as specific activities but from the fact that they are a community pursuing an enterprise'* (Wenger, 1998 p. 82). In other words, a community is

defined by valuing a *'shared repertoire',* here caring and kindness. Caring and kindness is introduced to the student midwives' '*repertoires'* through the formal teaching and practice experiences. As such, students' identities are negotiated through each aspect of their learning. To make this more meaningful; perhaps reflection on students' practice experiences, with a focus upon caring and kindness would be helpful. Importantly, the reification of the students' practice participation. Using reflection and the '*repertoires'* from students' practice may serve as a vehicle for constructing their professional identity as they work towards belonging to the CoP (Wenger, 1998). Other changes to foster caring, kindness and compassion are needed in the wider midwifery profession and perhaps requires some reimagining how this may be achieved (Kirkup, 2015).

My stance on fostering compassion in healthcare, starts with students' undergraduate midwifery education (Pearson, 2018). However, this raises questions about those already working within the midwifery profession. In attempting to address cultures lacking in compassion, it has been proposed that qualified staff need providing with: '*training that can help to cultivate compassion across the NHS'* (Henshall, Alexander et al., 2018, p. 231). Such interventions may be needed and seen as beneficial to those supporting students' learning. Additionally, Curtis et al., (2017) suggests that healthcare professionals need supporting to '*cultivate their compassion'* (Curtis et al., 2017 p. 155). The notion that compassion understanding can be enhanced with training, was suggested by Curtis et al., (2017) Cultivating Compassion Project. It was established to provide compassion training for NHS staff in the South East of England. This project being limited to only one location in the United Kingdom (U.K.) perhaps shows the lack of attention that compassion has

actually been given. This is in spite of knowing that compassion must underpin healthcare (Francis, 2013; NMC, 2018; 2019). Compassion development then amongst healthcare professionals, is and will continue to be highly variable where compassion is not given the attention required to foster or enhance the value in individuals. Cultivating compassion aimed to: '*develop, implement and evaluate a sustainable evidence-based programme of compassion awareness amongst health care professionals'* (Curtis et al., 2017 p. 151). This programme built upon research by Weng, Fox et al. (2014), which suggested that compassion training increases humane behaviour. Curtis, Gallagher et al., (2017) suggestion for training of an online toolkit including; '*digital stories, group activities and participants sharing their random acts of kindnesses'* (2017, p. 155) is useful. The findings showed that in '*Cultivating Compassion'* amongst healthcare professionals it served to promote the value in individuals (Curtis et al., 2017 p. 160) and subsequently the organisational culture. Therefore, cultivation of compassion, caring and kindness may become a '*shared repertoire*' amongst those supporting student's learning in the CoP, (Wenger, 1998, p.5). The overarching organisational cultures that students find themselves in will also have a bearing upon their learning about and for compassion.

5.6.5 Organisational culture

Organisational culture emerged as a theme and some students described how this had influenced their *'learning as belonging'* (Wenger, 1998 p.5) and their practice perspectives. Describing the organisational culture of the placement, this student said: *'I think there is danger of getting swept along, isn't there, when you're on placement'. And swept along with the culture of the department, of all the people that are there, and I think that the prior knowledge of what it*

might be like, it helped definitely' (=# 3). The findings also revealed that student perspectives on the organisational culture for some students had informed their impressions of compassion in a number of ways. Some noted the often negative organisational culture and a year one student said that she observed: *'quite a lot of moaning, which I know they shouldn't be moaning in front of students, but it was about the frustration that they don't have the time to be compassionate'* (=& 1).

Staff who were time-compromised, in part, may explain some of the sample groups' quotations including descriptions of often suboptimal organisational cultures. Such negative aspects, like the ones raised here, have implications for the future teaching about compassion. Students need to be encouraged how, in future, using the concepts learned during the module to better understand the '*moaning*' and the perceived lack of time to be compassionate. Furthermore, students need to be supported to analyse negativity and how, in, their future practice proactive solutions can counter pessimistic outlooks. Together, with an exploration of organisational culture and the realities of an often stretched maternity service with the potential that this may have upon providing compassionate care. Focusing on solutions rather than problems seems a way forward to foster compassionate cultures within organisations.

Students went on to describe the negative aspects about midwives being fearful of getting sued and this third year student said: '*I don't remember learning about defensive practice at university....which is actually, unfortunately, probably the driving force for a lot of stuff, umm, and fear, so I think I was*

shocked by that, and I think at first, I didn't recognise it because I didn't understand the risks....I didn't understand litigation. I think it would have been quite shocking to be told about that when you're a brand new student midwife' (=/3).

When I prompted the sample group to tell me more about their observations in practice, they described mentors who feared litigation. Furthermore, the reasons given for this were the high-workloads and overstretched services all further compounded by often too few staff providing the care. As the aspiration is that everyone accessing healthcare should be treated by compassionate healthcare professionals (DH, 2012, Francis, 2013, NMC, 2018, 2019) it is important to understand how such pressures may and do pose a serious threat to the compassionate '*care the NHS strives to deliver'* (Henshall, Alexander et al., 2018, p.231). Organisational pressures exerted upon individuals are at odds with being able to give compassionate care (Francis, 2013). The idea that an organisational culture can impact upon compassion is not a new idea and 'thought to be: *developed or not by the shape of the medical environment in which students learn*' (Pence, 1983, p. 190).

The progress of fostering compassion amongst healthcare professionals, seems- until recently- to have lost momentum given that Pence wrote this well over thirty years ago. This notion has been supported more recently by Curtis et al., (2012) who reported that students' socialisation into compassionate practice can only take place in environments where it is given importance. Indeed: *'what*

matters for learning' and becoming a full member of a CoP is an understanding of the negative aspects' (Wenger, 1998 p. 74). I take this to mean that Wenger proposes negative aspects of learning are part of the initiation into the CoP. The significance of Wenger's previous assertion is seen in the following student's quotation: *I think for me, the one I can look and think they're completely two different cultures, community in the two different Trusts. Umm, so I came out of community in the first trust thinking, "you've gotta get through that clinic, you just need-whatever you need to do and get everyone out of the door". And then I've gone to my second Trust and my mentor does not look at the clock. There's no rush, and, to me that has shown me true compassionate care' (=+3).*

As an educator, when teaching students there is often an aspiration to just present the positives of practice, rather than the negatives. This is premised on the idea that we do not want to discourage students from being future midwives. The findings have offered a new and helpful perspective upon this. Avoiding speaking about the negatives of an organisational culture is not helpful to the students' learning about compassion. Instead, it is important that students are introduced to the negative aspects that can impact compassionate care. Furthermore, it is important to present the useful concepts known to support the value. Making use of the pedagogies that explore students' narratives of negative organisational cultures, together with the how they might address these seems one way forward. Germane to the development of a compassionate midwife is the need to be self-aware.

5.6.6 Self- awareness

During phase one of the research, thirty eight percent of students hinted at a lack of self-awareness, which they said had prevented them from being compassionate in their past. Some of the comments included them: *'not taking the situation as seriously as I should'* (19), *'being judgemental'* (16, 12), *'not being there for someone'* (1) and *'not being sympathetic to homeless people'* (3). Self-awareness, is a basic prerequisite of all skilful healthcare (Burnard, (2002) and so is tantamount to forming an identity as a midwife. Moreover, self-awareness is: *'the fact of being a conscious, knowing human being'* (Burnard, 2002 p. 4) who have complex feelings and emotions.

Some hint of this is described by this student and: *'when my Dad was feeling suicidal, I got angry and upset taking it personally and I stopped talking to him for a few weeks. I wish I had been more compassionate and understanding and helped him in those few weeks'* (9). Analysing this student's quotation using Burnard's idea of self-awareness development in individuals is useful. Self-awareness, requires: '*thinking, feeling, valuing and evaluating*' our interactions with others (Burnard, 2002 p. 11). This student appeared to be *'thinking'* about past occasions when they had not been compassionate. Their quotation suggests *'feelings'* of '*upset'* and anger showing the complexity of such emotional responses and how they felt now looking back on this experience. They, were now '*valuing'* the need to be compassionate. Furthermore, that they were *'evaluating'* how they would do things differently in the future to be more compassionate. The majority, at sixty two percent of students in phase one of the research did not mention self-awareness as necessary for compassion in their responses. This suggests to me, the importance of teaching students about

the concepts of self-awareness during the compassion module. In contrast, the year two and three students' responses did not suggest a lack of self-awareness preventing them from being compassionate. Perhaps this was because these students had already been introduced to the concept of self-awareness during the compassion module. Self-awareness is a key skill for a midwife and forms part of professional identity development and in students': *'learning as becoming'* (Wenger, 1998, p.5).

During the compassion module, the pedagogy used to teach students about self-awareness was a lead lecture. This didactic approach explored with students used the lens of emotional intelligence (EI) (Goleman, 1995). Self-awareness is useful when considered alongside EI, as a number of scholars consider that key to understanding others we need to connect with our own feelings and emotions (Salovey and Mayer, 1990, Goleman, 1995). In turn, this supports an understanding about the feelings of others with the potential of improving our relationships (Salovey and Mayer, 1990, Goleman, 1995). Consequently, as humans have complex feelings and emotions the knowledge of EI may support interactions with others and ultimately them in being compassionate to others.

In the lead lecture on EI, students are taught about The Trait Model (Goleman, 1995). Together with self-awareness it describes three other aspects of EI including: social awareness, self-management and social skills (Goleman, 1995). Each have resonance with the ability to be compassionate as follows: social-awareness is the ability to be able to empathise with others (Goleman, 1995). Self- Management, is also useful for being compassionate, as it is said to control negative or disruptive impulses, which prevent us from saying or doing the

wrong thing during interactions with others (Goleman, 1995). Finally, Goleman, (1995) suggests that social- skills purportedly offer expertise in managing and building relationships and so are another key aspect of students' learning to be compassionate in practice. This student described change and development of their thinking about compassion following the formal study and when in practice: '*I had to 'be' and 'think' compassionately with everyone I came into contact with* (=*3). This showed that practice had offered the student opportunity to put some of the learned theory into her practice as she considered the feelings of others.

Introducing students to self- awareness through the concept of EI is perhaps useful to support the reification of compassion in relation to self and others. However, there are commentators who suggest that in the beginning self-awareness pedagogy needs to focus upon self rather than others (White, Logghe et al., 2018 p.35). This seems an overtly obvious assertion to this discourse. Nevertheless, self needs to be a focus and the: '*first step on the life-long journey toward understanding and developing accountable personal and institutional relationships with those both similar and different from oneself' (*White, et al., 2018 p.35).

Upon reflection and considering these students' thoughts, the current lead lecture in the compassion module introduced the idea of self-awareness to the students, it failed to get them to focus upon 'self' as White et al., (2018) suggest. To some extent this self-focus is achieved in practice; where the student identifies their learning needs, plans with the mentor how they will achieve this and finally self- assesses their own performance followed by the

mentor's assessment of competence (NMC, 2009, 2019). However, there appears a gap, then, between teaching of self-awareness during the compassion module and practice. A more joined-up approach could include small group reflection in the university exploring students' feelings in relation to themselves initially and then others, as they reflect upon their placement experiences.

Amalgamating practice and theory in this manner would mean: *'bringing them together through the construction of meaning, we construct who we are' (Wenger, 1998 p. 158).* In *'becoming'* a midwife, self-awareness and developing compassionate values are one aspect of establishing a professional identity. Identity formation is complex and its course dependent upon an individual's former experiences. Wenger (1998) suggests that: *'identity formation is: ongoing, over a long period, through the interactions with others, their environments and participation in the CoP'*. In midwifery, the academic and clinical midwives are the profession's gatekeepers', deciding whether students will become members of the midwifery profession or not. Such decisions are premised on whether a student has the required knowledge, skills, and attitude conducive to professional midwifery practice. Finally, Wenger's idea that practice does not exist in an '*abstract* way' (1998 p. 73) suggests the importance of both theory and practice to learn about and for compassion.

5. 7 Chapter summary

The chapter has explored and discussed three distinct yet interrelated phases that influence students' learning about compassion including: their pre-course life experiences, formal study and the learning and practising of compassion in practice. Wenger's (1998) CoP theory has framed the analysis with its focus of four interconnected and reciprocally defining constructs: *learning as experience (meaning); learning as doing (practice); learning as belonging (community) and learning as becoming (identity).*

It is useful to summarise the students' views that have informed this chapter using Kanov Powley et al., (2017) and Dutton, Workman et al., (2014) suggestion of a four step approach being needed for compassion. They suggest that compassion firstly requires noticing the other's suffering. We can see from the data presented here that students displayed differing capacities to notice; this is shown in the variations in their responses as they reflected on compassion. Secondly, Kanov et al., (2017) and Dutton et al., (2014) suggest that compassion requires an empathic concern. To some extent this seemed to depend upon students' prior life experiences and (to a lesser extent) their former education. Furthermore, some issues might be easy for some students to notice, empathise with and understand while others – especially those that are culturally alien to the student – might be harder to see, empathise with and understand. This is an important issue in trying to promote and enhance compassionate care. Thirdly, Kanov et al., (2017) and Dutton et al., (2014) suggest that an individual has to make sense of a situation.

The professional education then needs to introduce students to the key ideas associated with compassion and assist with Kanov et al., (2017) and Dutton et al., (2014) fourth point, which suggest that compassion requires action. It is anticipated that the formal teaching introduces students to the concept of compassion and that the practice placements allow them to put the value into action as they deliver care.

The final chapter will include a summary of my contributions to knowledge. I will also highlight the strengths, weaknesses and implications of my research findings for midwifery education and educators. Finally, I consider the potential of future research to further inform educating about and for compassion in midwifery education.

Chapter six:

6.1 Conclusions

This study has provided a detailed view of how student midwives may learn about compassion before and during their undergraduate midwifery education. The evidence base for educating about and for compassion in midwifery is far from being established. This study has offered some new and original insights. The emerging knowledge about compassion from this study will be useful for: student midwives; midwives; midwifery education providers; midwife educators; Heads of Midwifery maternity care providers and healthcare policy makers. The sample group have reported learning about compassion: through their pre-course life experiences; through formal study during the compassion module and in clinical practice. The findings are brought together in this final chapter and highlight what this study has shown to be useful in educating future midwives about and for compassion.

According to the sample group a number of ideas were germane to compassion and these have been presented in chapter four. These ideas have been, explored, synthesised and evaluated in chapter five. The study and its findings are considered to be original. To date, no research has focused solely upon student midwives who have received formal education about compassion. Therefore, the overall contribution of this study is to provide a novel insight from students who, since 2015 have been formally taught about compassion and how, in their own words this had influenced their learning. Wenger's (1998) Communities of Practice (CoP) Social Learning Theory has been a useful lens to analyse these findings as 50% of students' time on their course takes place within the clinical placements. This research has generated some key findings, which offer some answers to the

original research questions. These initial questions frame the discourse in this chapter. Firstly, I begin with a reflection upon my personal and professional reasons for undertaking this study.

6.2 Reflections on the study: personal and professional

The compassion module development began with a literature review, which revealed that educating about and for compassion was limited to a small body of evidence in nursing and medicine. However, the midwifery profession and its educators had not yet contributed to the discourse about how we should teach our future midwives about and for compassion. Undertaking the Professional Education Doctorate in 2015, offered an opportunity to design a study that would aim to explore how we may educate student midwives about compassion.

The aims of this study were to investigate student midwives' understandings of compassion and the impact that the taught theory and clinical practice elements of their education had upon their learning. This study aimed to explore and understand how theory and practice may potentially work together to facilitate student midwives' learning for and about compassion during undergraduate midwifery education. Alongside, the aim I also hoped to answer one main research question:

What and how do student midwives learn about compassion in an undergraduate midwifery course?

To build an answer to this central question, the following sub-questions were explored:

i) What do first year student midwives consider compassion to be before formally studying about it?

ii) How useful did student midwives find studying a module about compassion in changing their understanding?

iii) *How does working in clinical practice influence the student midwives' learning about compassion?*

This study has explored student midwives' understanding about compassion at three points, as they started the midwifery course; following the formal teaching about compassion and at variable points in their clinical practice dependent upon their year of study. As I commenced the research my views about compassion and its formal education, were limited. I thought that we could teach our students about compassion as they undertook the module. Finally, I considered that students' learning about compassion would be consolidated during their clinical practice experiences. However, undertaking this study and through analysing the findings my perspectives and understanding about how we may educate about and for compassion has been enhanced. The data collected and analysed suggests that students' education about compassion has three distinct, yet interrelated phases that influences their learning. These are the students previous: life experiences; the formal teaching about compassion and learning about and practising being compassionate in Clinical practice.

6.3 Life experiences

The answer to i). What do first year student midwives consider compassion to be before formally studying about it? Is shown through the analysis from phase one of the research and as students commence midwifery education, their understanding about compassion

arises from their life experiences including: their upbringings, relationships with others, schooling and for some, and their previous work interactions. This finding accords with others and they have described such phenomena as: 'foundational influences' which, are germane to an individual's understanding about compassion (Pence, 1983, Wear and Zarconi, 2007, Gilbert, 2009).

Students start their midwifery education with their pre-professional life experiences of compassion, bringing their understandings to both the classroom and clinical practice. Therefore, using Wenger's suggestion of *'learning as experience'*(Wenger, 1998, p.5) means that compassion already had a '*meaning'* attached to it and gained from the students' pre-course life experiences. The students' life experiences are highly variable including: their ages shown within the sample group ranging from 18-54. Some students will join the midwifery course from School and others have had established careers; they may or may not be parents or have care commitments.

Consequently, at this initial starting point, students' views of compassion are diverse. Such diversity amongst the student group shows that the duty ahead for the professional education is to ensure that both theory and practice assist all students to a minimum and accepted level of knowledge about compassion. This may then be put into practice during and at least by the end of the students' course (NMC, 2009, 2018; 2019). The emerging themes presented in chapter four (4.1, p. 91) were only thought necessary to consider alongside compassion by some students. Therefore, this says something about the importance of the formal teaching about compassion.

Thus, the formal teaching needs to introduce to all students the concepts and ideas known to be helpful for compassion as presented in chapter five (5.6, p. 153). In sum,

due to the diverse life experiences of students and their different demographic it seems a reasonable assertion that the formal teaching about compassion should begin early in students' midwifery education. I assert this idea based on the findings. As shown, students commence their undergraduate midwifery education at different starting points in their thinking and their individual experiences of compassion Teaching students about the ideas associated with compassion at the beginning of their courses may help them to begin the learning process. Additionally, to have developed at least a minimum understanding about what assists and inhibits compassion. Finally, it has been shown that students do not always encounter compassionate role models in practice. Therefore, the formal teaching about compassion should be prior to students' first placement to highlight what compassion is, and importantly what it is not.

6.4 Formal teaching, learning and practising being compassionate in Clinical practice

Theory and practice are inextricably linked and so here they are brought together in conclusion of how each support compassion and its learning. Two sub-questions examined the contribution of theory and practice to the students' learning: ii) *how useful did student midwives find studying a module about compassion in changing their understanding, and ii) how does working in clinical practice influence the student midwives' learning about compassion?* The answers arising from these findings have shown that most students in the age groups 25-64 reported that the formal study about compassion had to a greater or lesser degree changed their understanding about the value. I assumed this 'change' to indicate an increase in their knowledge and have evidenced this assumption in the students' own words in chapters four and five. The group

of students reporting that the compassion module had assisted their understanding the least were those aged between 18 and 24.

As this data was elicited by an anonymous questionnaire it has not been possible to explore this further or to understand why these students had not found the compassion module useful for their learning. Therefore, this is considered a study limitation.

Acknowledging that midwifery students move between theory and the CoP (Wenger, 1998 p.5) suggests that each will assist students in forming their own meaning about compassion. The formal teaching had assisted students to observe either the presence or absence of compassion during their practice placements. Therefore, formally teaching students about compassion is key to their initial and ongoing understanding. When students are taught about the ideas that support compassion the findings have shown that it becomes apparent to them whether compassion is present or absent during clinical interactions with women. In turn, this serves to influence the compassionate midwife they aspire to become. It also supports them in knowing the type of midwife they do not want to become. The findings have indicated that when educating about compassion consideration needs to be given to the curriculum design.

6.5 Curriculum design and compassion

This study proposes how an understanding of compassion may occur during undergraduate midwifery education and what may be useful for this learning. The spiral curriculum (Bruner, 1962, 1979) is one design that may be pertinent for educating students about compassion. Learning about compassion, like other deep learning, is recursive and so a spiral curriculum allows the required repetition and deepening understanding about a phenomena. A spiral curriculum

permits the topics taught to increase in their complexity, development and so the potential of increasing the students' knowledge. To achieve this, my findings suggest that compassion should be taught in all years of a midwifery course; unlike at my university where it is just taught in the first year. Unless compassion is taught in each year of the midwifery course, the students' practice experiences may go unexplored and vital learning opportunities may be missed. Theory and practice consequently needs to work together to deepen the students' knowledge about compassion. The sample group's quotations have revealed a number of useful narratives and these may have been used during the formal teaching, to deepen and develop students' knowledge about compassion. Interleaving theory and practice may be one way of achieving this and by using practice narratives to inform and build on the theoretical ideas and vice versa. The pedagogies thought to be most useful for the learning about compassion and its reification are supported by the findings from my study.

6.6 The reification of compassion and the pedagogies that may support this

Wenger's (1998) suggestion that reification of abstract concepts are needed for learning speaks to my previous suggestions of how theory and practice may work together to support learning about compassion. The findings have highlighted that students' have multiple stories from practice and in relation to compassion, these may offer valuable learning opportunities if revisited during the formal teaching about compassion. Importantly, students' stories would support them to make sense of the clinical interactions. Furthermore, as suggested by Anderson and Krathwohl, (2001) learning takes place in both the affective and cognitive domain. Therefore, students may reflect upon their 'real life' stories to deepen and demonstrate key points about the value in general. Moreover, the findings have

suggested that a number of different types of stories might be helpful, including students' personal stories from their life experience, with a focus upon compassion and lack of compassion. Some examples of such life experiences were exemplified and have been analysed in chapter five. Real life stories, chosen by the students may help them to explore the key points about compassion in midwifery. The stories that students may bring to the theory sessions may help them to develop their own meanings of the value. Additionally, by sharing stories with each other, this may present opportunities for students to explore and discuss situations yet to be experienced by them personally and this may add to their overall experiences.

Stories assist learning by offering '*meaning* 'to situations as*: 'stories can transport our experience into the situations, as they relate and involve us in producing the meanings of events as though we were participants'* (Wenger, 1998, p. 203). Therefore, moving through 'real life' stories of others alongside their own, may increase students' preparedness for future compassionate and professional practice. When students' personal stories about practice and in relation to compassion are used to facilitate learning, it shows how such encounters can build an account. In turn, there is the potential of each new story offering further learning opportunities to increase understanding (Gilkison, et al., 2016 p. 30). Stories shared by others from past experiences '*can also be integrated into our own identities as though we were participants'* (Wenger, 1998, p. 203). Finally, stories of 'self-compassion' (Neff, 2011 p. 5) are also important to learning about and developing as a compassionate midwife.

Being compassionate to self is considered key to being compassionate to others and so exploring stories about this idea is useful to assist students' learning.

Other pedagogies, supported by the findings- such as reflection-may progressively explore students' practice experiences. In turn this may help them to develop a theory around the role of compassion in midwifery and their identity as a reflective and compassionate midwife. Evidenced by the students' own words and interpretations of their experiences my findings have shown that some of the sample group reflected back on past practice experiences. Reflection, either in a written form or explored verbally (or both) in the classroom alongside students' stories to explore compassion may therefore be used to, support further learning. Students' practice experiences may be framed and given meaning using a reflective model, these notably vary and some are simple and others complex. For example, Driscoll's (2007) Model of Reflection, asks just three stem questions: What? ; So what? ; Now what? Therefore, simple models of reflection like Driscoll's (2007) may be useful for students in the early stages of their midwifery education in helping them to reflect about compassion. Using reflection from students' experiences about compassion may be as follows: the '*What'* stage of Driscoll's model may prompt learners to recall an experience. Highlighted by my findings, this may be when students' have seen compassion in practice or perhaps the absence of it. Moving onto the, '*So what'* stage would involve students exploring their experiences and analysing them alongside the taught concepts during the compassion module. Finally, the '*Now what'* stage of reflecting may prompt the student to consider the application of this new knowledge to future compassionate midwifery care.

Students in years two and three, may benefit from reflective models requiring a deeper examination of compassion in practice with the intention of supporting deeper learning that is built upon from the initial stages. Reflective models, like Gibbs (1988) for example aims to elicit feelings, evaluate and analyse practice experiences. Finally, it facilitates learners to conclude what else they may have done in that situation to potentially improve the outcome, and finally what action would be required in a similar future experience.

Models of reflection like Gibbs (1988) may support students in thinking progressively and by doing so deepening their knowledge about compassion as they progress through their education. Therefore, making use of reflection as a pedagogy when teaching students about compassion may help them to work through their feelings and emotions in a constructive manner to help them deal with these in the future.Curriculum design and the appropriate pedagogies are one way that supports students learning about, and for, compassion. The midwives within the CoP (Wenger, 1998) will support the students' learning in practice and considered as key role models.

6.7 Role models and compassion

The findings have revealed variations in compassionate role models supporting the students' learning in practice. This requires some considerations for the future teaching about compassion. For that reason, future teaching may focus upon students' experiences of mentors who are compassionate and those who are not. Both

organisational and individual reasons for these difference are useful to explore. For example, getting students to analyse the possible causes of non-compassionate behaviours amongst midwives is an important aspect when educating students' about compassion. Some scholars have suggested non-compassionate behaviours amongst individuals may be a result of working in an organisation premised on a payment by results system (Kirkham, 2015; Francis 2013). This may lead to financial resources and care focus directed toward the medicalised aspects of midwifery. In turn, this shifts the balance toward medicalisation rather than the softer skills and emotional work, including being compassionate (Kirkham, 2015). The teaching about compassion therefore needs to highlight this trend in midwifery. In turn this may support students to build their own a personal philosophy of compassion which, hopefully rejects simple, binaries such as medicalisation versus the softer skills like compassion. Therefore, teaching about compassion must emphasise its importance, despite students not always seeing others role-modelling the value. Formally teaching students about compassion followed by clinical practice builds upon students' pre-course life experiences. The findings have been summarised, however as with all studies, this research, has both strengths and limitations to be considered.

6.8 Study strengths and limitations

This is an original, important and much needed study that will benefit the midwifery community and beyond. Nonetheless, its relative strengths and weaknesses must be acknowledged and these have been woven together in this section. Paying attention to detail, being accurate and methodical as I

approached the research is considered a strength. Countering, any design weaknesses and procedures that may impact and weaken the research findings (Cohen et al., 2011).

As a novice researcher, undertaking this study has assisted me to develop the knowledge and necessary skills to conduct future research. Furthermore, consulting with my supervisors at key points whilst undertaking the research allowed me to develop my own high order problem solving skills, through the discussions of my ideas with experienced researchers. The skills learned through the completion of a Professional Education Doctorate will be invaluable for my future career development as both an educator and researcher.

I collected data from the students at my university and was also the compassion module lead, this placed me in a privileged position for the data collection. I was mindful of what McCann and Clark (2005, p. 42) warn about researching our own students, which may lead to an*: 'abuse of power, coercion, and lack of confidentiality and absence of meaningful consent'.* These tensions were uppermost in my mind throughout the data collection and have been set-out in chapter three (3.3, p. 66).

I was mindful to mitigate against any harm arising from the students' participation in the research. As such, their names were not added to the free writing documents or questionnaires so as to protect their traceability. Additionally, those attending the Focus Groups volunteered to do so. I attest that the research questions may only have been answered by collecting data

from the students studying at my university given their unique education about compassion. Nonetheless, I acknowledge that researching the students we teach is a research limitation.

The research aim and questions were, on the one hand wanting to elicit depth and breadth as achieved by the qualitative methods used and on the other hand working with scope and scale that the quantitative approach sought to respond to. The three methods used were: the free writing exercise (phase one); self-completion questionnaires (phase two) and phase three comprised of focus groups. This offered a triangulation of the methods and so is considered a strength. With the exception of the free writing method, other research, exploring compassion has used similar approaches to collect their data as described in chapter two (2.5, p. 38). Therefore, this offers a rationale for and is a strength of the study design. I have not located any other research collecting data using a free writing approach to examine learning about compassion. However, no other studies, have aimed to elicit data about compassion from their sample group prior to commencing upon undergraduate midwifery education. This is a strength of the research as data has been collected pre and post studying about compassion.

This data has shown that studying a module about compassion followed by practice informs students' learning about the value of compassion. No other studies to date have offered this perspective and so is considered a strength of this study. Additionally seeking students' views about compassion prior to them

undertaking their midwifery education has given a unique insight into their life experiences that may have informed their initial thinking about compassion.

The qualitative aspects of the study sought to illuminate new insights about the questions under examination. However, like any qualitative method it has not resulted in a definitive truth; there are no right or wrong answers. Instead, important to the exploration within this thesis were the sample groups' perspectives. This research therefore, cannot claim to be generalisable or easily replicated, instead the significance lies in the students' own words. The quantitative aspects from the questions asked students to say if the module had changed aspects of their understanding about compassion: '*a lot'*; '*a bit'*; '*not much*' or '*not at all'*. This data has not been subjected to any statistical tests as the aim was to show any reported difference to the sample group's understanding about compassion following the teaching. Additionally, how much or little working in practice had upon their understanding about compassion. This may be considered a research limitation as I cannot claim to have subjected the data to 'statistical treatments' (Cohen et al., 2011). It is acknowledged that the success of focus groups may be premised upon the researcher's abilities and interview technique. As a novice researcher and on reflection, if I consider the first focus group I facilitated compared to the second and third the latter two were approached with more confidence and possibly competence.

It is acknowledged this may have affected the data collected from the first focus group sample. There were also a smaller number of participants in the year two

group compared with years one and three. Therefore, this may be considered a study limitation. Perhaps, using individual interviews may have provided more in-depth data for the year two group. Being known to the participants may have influenced their individual and collective responses. It is hard to know if the sample group said what they thought I wanted to hear, however, there seemed to be a balance between the positive and negative responses. I therefore have concluded that students were being true to their 'real' experiences' during the focus groups.

I transcribed all of the focus group data for the reasons explained in chapter three (3.7.3, p. 87). Whilst this helped me to become familiar with the data I realise that errors may have occurred during this process, despite approaching it meticulously and paying attention to the detail. A final and important aspect of the research process is to communicate the findings of the research (Cohen et al., 2011).

6.9 Dissemination of the findings

6.9.1 Dissemination during the thesis completion

My published critical reflection on educating about compassion in the British Journal of Midwifery (Pearson, 2018) shows that dissemination of this research started at an early stage and prior to the study's completion. As a direct result of

this publication, networking opportunities have arisen and potential of future research collaborations have arisen.

In 2019 I facilitated five days of workshops for Indonesian Midwifery Educators implementing degree level midwifery education in their institutions. One of my presentations focused on how we may educate about and for compassion. Completion of the thesis leads onto a consideration of the short term plans for the dissemination of the research over the next six months.

6.9.2 Dissemination plans: six months and beyond

Dissemination of the research allows its findings to be appraised by others and scrutinised in terms of how methodology. It may be suggested that this starts with the viva examination when the internal and external examiners appraise and scrutinise the research. Such examination of the research supports its usefulness or otherwise in the field. The field includes relevant people including; the sample group, local, national and international midwifery educators, the Lead Midwife for Education locally. The research may also be of interest to other researchers interested in educating future healthcare professionals about compassion. The maternity services policy makers may also be interested in what this study has found. Additionally, Heads of midwifery overseeing student midwives practice placements may be interested to hear about the students' observations of compassion across their workforces.

The dissemination in my own university will include presentations to students, midwifery colleagues and the wider School. The findings will be presented to students' trust placements and midwifery colleagues. I intend to present at national and international education and midwifery conferences, including the Universitas 21 online conference. As this organisation works across 27 world class universities, this offers a global platform to disseminate my research.

I will also write for publication to ensure these findings reach a wide number of the midwifery profession. This will hopefully assist in an increased awareness of the emerging issues from the research. However, changes in the way that we educate future midwives about and for compassion will require more than just the dissemination of these findings alone. Midwifery education providers will need to consider how compassion should be introduced in undergraduate education and practice alike if it is to become anything other than a widely used word that is not well understood (Pearson, 2018).

6.10 Recommendations for midwifery education

There are some key concepts that as midwifery educators we need to focus our attention if compassion is to be successfully learned by our students. The ideas that follow have already been presented, discussed and justified, below is a summary:

- educating about and for compassion in undergraduate midwifery education needs to start at the beginning of the course. This allows students to start to build on their life experiences of compassion; the formal education about the value and their experiences from practice. When the ideas associated with compassion are

introduced to students at the beginning of their education it supports them in seeing the value of compassionate care;

- midwifery curricula including those utilising a spiral design are useful to support the learning about compassion as it promotes recursive and deep learning;

- a spiral curriculum design allows the theories associated with compassion to be revisited with increasing complexity during each year of the course. In turn, this helps students' to build upon the theory and practice to further deepen their learning about compassion;

- interleaving theory and practice may be one way of improving students' practical application of compassion to their midwifery care delivery;

- pedagogies that support students to explore their thoughts and feelings in relation to compassion are useful: in particular stories about the students' practice experiences;

- role-play may support students to explore midwifery scenarios and their responses to these for future application to midwifery practice;

- reflecting in and on practice is key to the development of a reflective and compassionate midwife;

6.11 Further research

This study has predictably led to further questions and so offers some future research opportunities. The findings have shown that formal study about compassion highlights to students when it is present or absent during care interactions. Furthermore, there were variabilities and inconsistency amongst those supporting student learning in relation to compassion.

This leads to questions about the reasons for this and so are worthy of further investigation. The specific focus of further research, then, should focus upon;

'Exploring midwifery mentors' perspectives about compassion'.

Additionally this study has highlighted that midwifery teachers may require additional continued professional development to better support their knowledge about student learning and the pedagogies that may best support this. Specifically research that explores;

'Midwifery educators continued professional development needs in higher education'.

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Appendix one

Factual outline of the Compassion Module

Module content

The module content included an exploration of the midwife's role and the historical overview of midwifery since the start of the century. Values as an important aspect of healthcare, were explored alongside the Department of Health's 'Six Cs' and the National Health Service (NHS) Constitution. Compassion and its varied definitions were deliberated. Additionally, the ideas around how empathy and sympathy differed from compassion were also explored. Three separate yet interrelated sessions focused upon communication and professionalism. The communication session included theories about verbal, non-verbal, written and visual communications in relation to compassion. Two further sessions facilitated students' learning about professionalism, the regulatory framework and the professional standards in midwifery. Emotional intelligence (EI), self- awareness and using reflection in and on clinical practice to support learning was also covered as part of the module.

A number of philosophies thought useful for building supportive relationships including: why relationships are required in an evolutionary and physical context and how the mother-midwife relationship is beneficial to midwifery care were taught. The key drivers within the maternity services including continuity of carer were also discussed as part of the module.

Given the often stressful aspects of midwifery, there were three sessions focused around resilience, organisational culture and ethical principles. The resilience

session covered concepts like mindfulness and being compassionate to self. The students were encouraged to pursue interests, for example exercise, alongside their studies. Students were encouraged during the session to consider how self-compassion, as a strategy, might help them to reduce stress during their education and onward midwifery careers. Teaching about ethics focused upon the midwife's ethical duty to provide care premised on the ethical principles of utilitarianism, deontology, beneficence, Non- maleficence, justice, truth-telling, autonomy and accountability. Midwifery case studies and scenarios were used to illustrate how these principles may be applied to midwifery care. Finally, the NHS's, organisational culture and how this influences compassionate care was explored.

Module pedagogies

The module's online learning tasks preceded all of the previously mentioned content. Completion of key tasks by students prior to the face-to-face sessions, helped their knowledge about the topics further built upon in class. At the heart of the seminars was a didactic style lecture (PowerPoint- led presentation) followed by dialogic learning, which took place through group break-out activities. Group work included discussion with peers to analyse and evaluate any practical experiences that they could apply to the topics under discussion.

Module assessment

Students were expected to choose and answer one of the following three questions:

1. Explain how knowledge of professional attributes and emotional intelligence supports midwives in their role as compassionate practitioners.

2. The professionalisation and regulation of midwifery fails to recognise the importance of compassion and development of emotional intelligence. Discuss.

3. The concept of compassionate care is central to the midwife's role and regulatory framework. Discuss.

The essay word count was a maximum of 3000 words. This word count was pre- determined by the university regulation of a 20 credit, undergraduate academic module.

Appendix two: Participant Information Sheet

Title of Study: Exploring student midwives understanding about compassion before and during their undergraduate midwifery education

My name is Maria Pearson I have worked within midwifery for the past fifteen years as an educator and clinical midwife.

I would like to invite you to take part in my research study. Before you decide I would like you to understand the reasons the research is being undertaken and what it would comprise for you. If required I will go through the information sheet with you and answer any questions that you may have. Talk to others about the study if you wish. Please ask me to clarify if there is anything that is not clear.

What is the purpose of the study?

Higher Education Institutes teaching midwifery need to implement values based education in response to the key drivers emerging from the Francis Inquiry (2013) and the National Health Service Constitution. These values are The 'Six Cs', and the aim of this research is to look specifically at compassion. Compassion has not previously been taught within midwifery education so the evidence-base upon the teaching and learning of this value within midwifery is virtually non-existent. This research hopes to add an original contribution to the body of knowledge surrounding this value in relation to midwifery.

Why have I been invited?

You are being invited to take part because you are student midwife in the first, second or third year of a pre-registration midwifery degree and have undertaken and been taught a module about compassion.

Do I have to take part?

No, taking part is voluntary. If you decide to take part you are still free to withdraw at any time and without giving a reason.

Taking part, what is expected of me?

You may be involved in three potential phases of the research dependent upon your year on the midwifery course:

1. Free writing in relation to compassion prior to starting the B71 M12 module
2. Questionnaire completion
3. Focus groups

This would involve you attending a group meeting in a room that will be advised before the date and it will be at the University of Nottingham. The meeting will take up to one hour of your time. The focus groups will comprise of approximately six to eight student midwives. If you want to take part in this stage of the research then you will need to indicate this to the researcher following completion of the questionnaire. The researcher can then get in touch with you to let you know the date, time and venue of the relevant focus group meeting. Light refreshments will be provided at these focus group meetings. At the focus group the researcher will ask you some questions and audio-tape the discussion to enable later transcribing and to facilitate an understanding of the context and points raised. You can expect to be asked about your experiences of completing the compassion module and your practice placement experiences. During the focus groups confidentiality will be adhered to and participants will not be identified.

You can decline to be involved in any of the three activities.

Will my taking part in the study be kept confidential and how will the data be stored?

Any information that you provide will be kept strictly confidential and following the researcher analysing the data it will be anonymised. The information collected will be stored on a secure computer drive, password protected and the questionnaires will be

kept in a locked cabinet within a locked office according to the University of Nottingham archiving policy, which sees data stored for seven years post publication and then disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality. Only the researcher and two academic supervisors will have access to your completed data. Once the information is transcribed from the audio-tape this will also be kept for a period of seven years and not reused during this period. Following seven years this recording will be deleted by recording over it. Ethical and legal practices will be followed and all information about you will be handled in confidence and any quotations from interviews used in any publications will be anonymised.

What will happen to the recorded data?

The data from the audio recording will be transcribed as written words to make the recording readable and meaningful. Then the researcher will look for emerging themes within the written text. The analysed data will be used in the EdD Thesis and any publications arising from this. All publications will be anonymised and will not be written in a way that any students could be identified.

What are the possible benefits of taking part?

It is hoped that the findings gained from this research may inform future midwifery education relating to compassion, values based recruitment selection strategies and national policy implementation.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the University of Nottingham's School of Education's Ethics Committee and the School of Health Sciences.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions, alternatively you can speak to my supervisor Professor Christine Hall.

Email: Christine.Hall@nottingham.ac.uk

What will happen if I do not want to proceed with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason. If you withdraw then the information collected so far cannot be erased and this information may still be used in the research analysis.

For further information and contact details

Ethics research office contact details
Email: educationresearchethics@nottingham.ac.uk

Researcher: Maria Pearson
Email: maria.pearson@nottingham.ac.uk

Appendix three: Consent form for participants

INTERVIEW CONSENT FORM
Title of Study: Theorising and Defining Compassion in Midwifery Education
REC ref: 2017/107
Name of Researcher: Maria Pearson

Name of Participant:

I confirm that I have read and understand the information sheet and have had the opportunity to ask questions.
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that data collected in the research will only be reviewed by the researcher and my two supervisors from the University of Nottingham. Only the researcher and supervisors will have access to the data. I give consent for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this research. I understand that my personal details will be kept confidential.
I understand that the focus group interview will be recorded and that anonymous direct quotations from the interview may be used in the EdD Thesis and in any future publications arising from the research.

I agree to take part in the above research.

Name of Participant: **Researcher: Maria Pearson**
Signature:
Date:

Appendix four: Self-completion questionnaire

University of Nottingham
UK | CHINA | MALAYSIA

Research Study on Compassion in Midwifery

Thank you for taking part in this research, which aims to investigate the teaching and learning of compassion to offer a new insight for midwifery education. I am very interested to gain your views.

1) About you, please tick or circle:

What is your age category?	Which Year are you in?
18-24 years old	Year one
25-34 years old	Year two
35-44 years old	Year three
45-54 years old	
55-64 years old	

2) What did compassion mean to you before you took the module about it? Please comment

3) Did taking a module about compassion change your understanding of it?
Please tick a box:

Yes, a lot		**Yes, a bit**		**Not much**		**Not at all**	

Please comment

Please turn overleaf

4) Did studying compassion help prepare you for practice?
Please tick a box:

Yes, a lot		Yes, a bit		Not much		Not at all	

Please comment

5) How do you think that working in practice has changed your understanding of compassion?
Please tick a box:

Yes, a lot		Yes, a bit		Not much		Not at all	

Please comment

6) Any other comments about compassion in midwifery?

Thanks for completing this questionnaire, your opinions are very valuable to me and will be used to inform midwifery education. Maria Pearson.

Appendix five: Ethical approval letter

University of Nottingham
UK | CHINA | MALAYSIA

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University of Nottingham
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educationresearchethics@nottingham.ac.uk

24/11/2017
Our Ref: 2017/107

Dear Maria Pearson
CC Prof Chris Hall and Dr Jenny Elliot

Thank you for your research ethics application for your project:

Theorising and defining compassion in a midwifery education

Our Ethics Committee has looked at your submission and has the following comments.

- Thank you for supplying a detailed account of how you had amended the documents. .

We confirm that

1. You have told us how are the students to be invited to participate in this research.
2. You have provided the contact details of the ethics research office need to be provided to participants on the information sheet. Please note complaints should be directed to this email address.
3. You have confirmed you will be present and available to answer questions from participants during the 'free writing' and 'questionnaire' phases of the research?
4. You have provided some idea of how long the 'free writing' and 'questionnaire' are planned to take; where they will take place; and what they will be asked about.
5. You have provided information about what will be asked, where their personal data are to be stored and how these will be used, analysed and reported.
6. You have removed regference to 'sanctioned' staff.
7. We have noted that you do not see 'compassion' as a 'sensitive' topic.

Based on the above assessment, it is deemed your research is:

- **Approved.**

Good luck with your research.

Dr Kay Fuller
Chair of Ethics Committee

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Appendix six: Interview schedule for use with Focus Groups phase three

Length of time up to 60 minutes

Maximum number of participants eight

Hello my name is Maria Pearson I have been a midwife for the past sixteen years and a midwifery educator for almost ten of those years. As the previous module lead for the compassion module my research interest is to investigate the teaching and learning of compassion with first, second and third year student midwives. Thank-you very much for taking part

Interview Questions

Probe question (should introduce participants to the discussion topic and make them feel more comfortable about sharing their opinions with the group.

1) What did compassion mean to you before starting the midwifery course?

Follow-up questions and prompts:

i) Tell me more about that
ii) Can you expand upon that point please?
iii) Can you give me an example please?

2) How did the compassion module change your understanding?

Follow-up questions and prompts:

i) Tell me more about that
ii) Can you expand upon that point please?
iii) Can you give me an example please?

3) How did the Compassion Module prepare you for your practice placements?

Follow-up questions and prompts:

i) Tell me more about that
ii) Tell me if it didn't work
iii) Can you expand upon that point please?

4) If you were able to be prepared for your first placement again, is there anything that you think needs to be covered in relation to compassion that was not covered in the module?

Follow-up questions and prompts:

i) Tell me more about that
ii) Tell me if it didn't work
iii) Can you expand upon that point please?
IV) Can you give me an example please?

5) How did you prepare for your first placement in terms of compassion?

Follow-up questions and prompts:

i) What I mean by this is did you use or consider any of the content covered in the compassion module during the placement?
ii) Can you expand upon that point please?

5) Describe if the placement was what you expected in relation to compassion?

Follow-up questions and prompts:

i) What I mean by that is did the theory covered in class transmit to the placement?
ii) Can you expand upon that point please?

6) What is the midwifery culture like on your placement?

Follow-up questions and prompts:

i) What I mean by with this question is the communication that you have witnessed with women and their families as you expected it to be?
ii) Why do you think that may be the case?
iii) Do you feel that the value of compassion is always shown to women and their families?
IV) Why do you think that this may be?
V) Can you give me an example?
Vi)Can you expand upon that point please?

8) What were the main differences between learning about compassion in the university and learning how to use the value in practice?

Follow-up questions and prompts:

i) What I mean by this is did you use any of the theory covered in university during the placement?
ii) Can you expand upon that point please?

Exit questions

9) Are there any questions I have not asked you that you have expected me to?

10) Have you any other comments about this topic that you wish to add?

Thanks very much for your time

Appendix Seven: Year one, questionnaire, quantitative data

Age groups	**Q3** Did taking a module about compassion change your understanding of it?	**Q4** Did studying compassion help prepare you for practice?	**Q5** How did you think that working in practice has changed your understanding of compassion?
Group A 18-24	**YAL** n = 2 **YAB** n = 5 **NM** n = 0 **NAA** n = 2 Total responses 9	**YAL** n = 4 **YAB** n = 3 **NM** n = 2 **NAA** n =0 Total responses 9	**YAL** n =0 **YAB** n =3 **NM** n = 6 **NAA** n = 0 Total responses 9
Group B 25-34	**YAL** n = 4 **YAB** n = 6 **NM** n = 1 **NAA** n = 0 Total responses 11	**YAL** n = 4 **YAB** n =6 **NM** n = 1 **NAA** n = 0 Total responses 11	**YAL** n = 3 **YAB** n = 6 **NM** n = 1 **NAA** n = 0 Total responses 10 one participant did not answer
Group C 35-44	**YAL** n =0 **YAB** n = 1 **NM** n =0 **NAA** n = 0 Total response 1	**YAL** n = 1 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 1	**YAL** n = 0 **YAB** n = 1 **NM** n = 0 **NAA** n = 0 Total response 1
Group D 45-54	**YAL** n =0 **YAB** n = 1 **NM** n =0 **NAA** n = 0 Total response1	**YAL** n = 0 **YAB** n = 1 **NM** n = 0 **NAA** n =0 Total response 1	**YAL** n = 0 **YAB** n = 1 **NM** n = 0 **NAA** n = 0 Total response 1
Group E 55-64	**YAL** n =0 **YAB** n = 0 **NM** n =0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0

Appendix eight: Year two, questionnaire, quantitative data

Age groups	**Q3** quantitative response Did taking a module about compassion change your understanding of it?	**Q4** quantitative response Did studying compassion help prepare you for practice?	**Q5** quantitative response How did you think that working in practice has changed your understanding of compassion?
Group A 18-24	**YAL** n = 0 **YAB** n = 9 **NM** n = 7 **NAA** n = 2 Total responses 18	**YAL** n =4 **YAB** n = 8 **NM** n = 3 **NAA** n = 3 Total responses 18	**YAL** n = 6 **YAB** n = 8 **NM** n = 2 **NAA** n = 1 Total responses 17 one participant did not answer
Group B 25-34	**YAL** n = 3 **YAB** n = 2 **NM** n = 1 **NAA** n = 0 Total responses 6	**YAL** n = 4 **YAB** n = 2 **NM** n = 0 **NAA** n = Total responses 6	**YAL** n = 5 **YAB** n = 0 **NM** n = 1 **NAA** n = 0 Total responses 6
Group C 35-44	**YAL** n =2 **YAB** n = 2 **NM** n =0 **NAA** n = 0 Total response 4	**YAL** n = 2 **YAB** n = 2 **NM** n = 0 **NAA** n = 0 Total response 4	**YAL** n =2 **YAB** n = 1 **NM** n = 0 **NAA** n = 0 Total response 3 one participant did not answer
Group D 45-54	**YAL** n =1 **YAB** n = 1 **NM** n =0 **NAA** n = 0 Total response 2	**YAL** n = 1 **YAB** n = 1 **NM** n = 0 **NAA** n = 0 Total response 2	**YAL** n = 1 **YAB** n = 1 **NM** n = 0 **NAA** n = 0 Total response 2
Group E 55-64	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0

Appendix nine: Year three, questionnaire, quantitative data

Age groups	**Q3** quantitative response Did taking a module about compassion change your understanding of it?	**Q4** quantitative response Did studying compassion help prepare you for practice?	**Q5** quantitative response How did you think that working in practice has changed your understanding of compassion?
Group A 18-24	**YAL** n = 4 **YAB** n = 9 **NM** n = 2 **NAA** n = 1 Total responses 16 one participant did not answer	**YAL** n = 5 **YAB** n = 9 **NM** n = 1 **NAA** n = 1 Total responses 16 one participant did not answer	**YAL** n = 9 **YAB** n = 6 **NM** n = 1 **NAA** n = 1 Total responses 16
Group B 25-34	**YAL** n = 6 **YAB** n = 2 **NM** n = 1 **NAA** n = Total responses 9 one participant did not answer	**YAL** n = 5 **YAB** n = 4 **NM** n = 1 **NAA** n = 0 Total responses 10	**YAL** n = 7 **YAB** n = 3 **NM** n = 0 **NAA** n = 0 Total responses 10
Group C 35-44	**YAL** n =1 **YAB** n = 1 **NM** n =0 **NAA** n = 0 Total response 2	**YAL** n = 0 **YAB** n = 2 **NM** n = 0 **NAA** n = 0 Total response 2	**YAL** n = 0 **YAB** n = 1 **NM** n = 1 **NAA** n = 0 Total response 2
Group D 45-54	**YAL** n =0 **YAB** n = 0 **NM** n =0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0
Group E 55-64	**YAL** n =0 **YAB** n = 0 **NM** n =0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0	**YAL** n = 0 **YAB** n = 0 **NM** n = 0 **NAA** n = 0 Total response 0

Appendix ten: Excerpt of Focus Group transcript

19/04/18

Key to speakers

Moderator = =

Participant 1 = /

Participant 2 = \

Participant 3 =#

Participant 4 =+

Participant 5 = *

Participant 6 =&

= = Hello, my name is Maria Pearson. I have been a midwife for the past sixteen years and a midwifery educator for almost ten of those years. As the previous module lead for the compassion module my research interest is to investigate the teaching and learning of compassion with first, second and third year student midwives. Thank-you very much for taking part. This is focus group number three and it's the 19th of April, 2018.

[0.00.26.0]

== So I'd like to start with the first question, to the group and that is: what did compassion mean to you before starting the midwifery course?

=/ [everyone looked to me] Umm, for me it felt like you were going, helping someone go through their pain or frustration or anything at the time that they're worried or concerned about.

It was like being with them as they- supporting them as they were going through it.

=\ Yeah I saw compassion not as a sort-of multilayer thing which is what we learn about. I sort of thought it was similar to =/, sort of kindness, but slightly more extended and that it includes sort of empathy. I didn't realised there was several layers to it.

=# I kind of saw it as like you just had a real want to help people like. If you saw someone in pain, all you wanted to do was help them. I didn't kind of see it as just even in your general conversations, compassion can come through. I didn't really think of it as something that happens all the time if you want it to. I saw it as like a just associated with like pain and suffering.

=+ I always thought of it as trying to understand somebody and then, if they needed help and being what that person needed at that moment.

[0.01.55.2]

== Thank you, so the next question is so: How did the compassion module change your understanding?

=\ I think the compassion module introduced us to different ideas about compassion so, forms of emotional intelligence, and umm, about resilience and how all these things are needed to overall create compassion. It's not just a simple- and it includes many different ideas.

=# I didn't quite understand about compassion, sometimes it can kind of be like that tough-love thing but it can sometimes- sometimes the most compassionate thing to do is not what not what somebody would necessarily

want but what the best thing is for them, like telling them how it is rather than being really fluffing it up kind-of thing. That I didn't really see it as- I kind of saw it as always being really nicey-nicey but actually sometimes the best thing to do-

=/ is be honest

=# Yeah, be honest yeah.

=/ mmm, that's what I thought as well. I thought that- before, umm, probably related it to more, like you say, being nicey-nice but obviously after the compassion module, you realise that you can- you can be mean to be kind- kind-of thing. You don't have to just put your arm round somebody and be compassionate.

=+ tell people what they want to hear

=/ Yeah, not just tell them what they want to hear, but do what you know should be done as well, for the best.

=+ I think for me compassion, the compassion module changed it from being about me being the person who was affected almost you're kind of doing it for your own benefit- not your own benefit but your own self-gratification whereas umm compassion umm in practice, being about the other person's well-being and them having the control, them having, umm-

=/ -the strength to like do what is necessary.=+ Yeah, and the decision making going from you being somebody who's doing something for somebody to you being someone who facilitates them doing it for themselves.