

# A concept analysis of compassionate midwifery

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TITLE PAGE

**Title:** A Concept Analysis of Compassionate Midwifery

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## ABSTRACT

**Aim:** To report a concept analysis of compassionate midwifery

**Background:** Recently compassion has been incorporated into United Kingdom nursing and midwifery language through strategy, policy, recruitment and education. Professional standards direct midwives to practise compassionately therefore the concept of compassionate midwifery exists, although this has yet to be explored as a concept in the United Kingdom or internationally. An understanding of what constitutes compassionate midwifery has the potential to increase midwifery knowledge and improve practice.

**Design:** Concept Analysis

**Data Sources:** Literature from 1990 - 2015 was searched using MEDLINE, CINAHL, PsycINFO and ETHOS. Grey literature and examples of everyday usage of the concept were searched using Google

**Methods:** An adapted model of evolutionary concept analysis.

**Results:** Explanations of compassionate midwifery were absent in the literature therefore the gathered data were evaluated in relation to elements of the compassion process: recognition of suffering, emotion, motivation and action. Compassionate midwifery is defined as the interrelations of authentic presence, noticing suffering, empathy, connectedness/relationship, emotion work, motivation to help/support,

empowering women and alleviating suffering through negotiation, knowledge and skills. Antecedents and consequences were also identified and depicted in a schematic representation of the concept.

**Conclusion:** This concept analysis provides a unique examination of compassionate midwifery and starting point for reflection on practice, education and further analysis. Empirical studies will provide the potential to take the process further by studying the experience of compassionate midwifery from different perspectives. A theory of compassionate midwifery will develop as new findings emerge.

**Keywords:** compassion, midwife, maternity, concept analysis, birth, kindness, empathy, suffering, nursing

## SUMMARY STATEMENT

### **Why is this research or review needed?**

- There is widespread agreement that healthcare including midwifery needs to incorporate compassion
- Analysis and research about compassion has so far been focussed on nursing
- Academic study on what compassion means in terms of midwifery care is missing

### **What are the key findings?**

- Ways the process of compassion is demonstrated in midwifery care
- Identification of the antecedents, attributes, consequences and scope of compassionate midwifery
- The first schematic representation of compassionate midwifery

### **How should the findings be used to influence policy/practice/research/education?**

- Findings should be used in clinical and educational settings to develop an understanding of compassion in midwifery and aid reflection on practice

- This concept analysis should be used as a platform for launching empirical research into compassion in midwifery which will build theory

## INTRODUCTION

Compassion in healthcare is widely considered to be desirable and there has been renewed interest in the concept over recent years. Compassion has both emotional and behavioural elements and can be seen as a process that starts with the recognition of another's suffering and incorporates behaviour aimed at alleviating that suffering (Gilbert 2009). Although this concept is well-established in nursing (Bradshaw 2011, Straughair 2012a, Von Dietze & Orb 2000), how it is demonstrated in midwifery has not been explored or studied. Nevertheless, the word compassion is now evident in many aspects of midwifery and is seen as 'absolutely fundamental to good quality maternity care' (Byrom & Downe 2015 p9). Moreover, an absence of compassionate care contributes to women's distress and poor outcomes throughout the world (Bohren *et al.* 2015) and the International Confederation of Midwives (ICM) calls for midwifery care based on compassion, dignity and human rights (ICM 2011).

Alongside the 'valiant rhetoric' of compassion in midwifery, Byrom (2015) asks how do midwives actually 'do' it? It may be that there has been an assumption that everyone understands what compassionate midwifery is. But little is known about what it means to women who receive midwifery care or whether midwives and women have the same understanding. Therefore, it should be considered a new and evolving concept in midwifery that needs to be studied as it has the potential to contribute to midwifery theory and practice. Concept analysis was chosen as a starting point for this process to identify, describe and clarify the concept of compassionate midwifery and establish the current state of its art and science (Hupcey & Penrod 2005).



## **BACKGROUND**

Compassion in UK healthcare emerged as a core value and a key concern (Kneafsey *et al.* 2015, McCaffrey & McConnell 2015) in the aftermath of a damning report on care in Mid Staffordshire (Francis 2013). To address the media outcry and public concern the Chief Nurse launched a vision and strategy for nursing, midwifery and care staff in the National Health Service (NHS) where the 6 Cs formed the elements of a 'culture of compassionate care'. These were: care, compassion, courage, communication, commitment and competence (Cummings & Bennett 2012). Following this the word 'compassion' was incorporated into healthcare strategy, policy, recruitment and education (Fry *et al.* 2013; McLean 2012 and Waugh *et al.* 2014).

Nursing has always had a strong association with compassionate ideals (Straughair 2012a) and has undergone considerable exploration and analysis of compassion (Davison & Williams 2009, Schantz 2007, Schofield 2012, Straughair 2012b and Von Dietze & Orb 2000). There have also been several studies designed to explore compassion in the context of acute care for older people (Dewar & Nolan 2013 and Perry 2009) and on general hospital wards (Bramley & Matiti 2014 and Curtis 2015).

However, midwifery is a separate profession in many parts of the world and a special branch of nursing in others. Midwives support predominantly healthy women who are going through a normal physiological process that is also a life-changing event and rite of passage (Jacinto & Buckley 2013). Undoubtedly, midwifery and nursing share much in common but they are distinct enough to consider that they may have developed significantly different interpretations of the concept of compassion.

Compassion in midwifery is a relatively new concept. Although hailed as a fundamental concept in caring (Chambers & Ryder 2011) it was largely absent from midwifery textbooks and professional guidance prior to 2012. As the 6 Cs (Cummings & Bennett 2012) filtered through to midwifery there was little analysis; rather it became something of a ‘buzz word’ and current *modus operandi* for the profession. This was strengthened when the updated Midwives Rules and Standards (NMC 2012:15), that came into force in 2013 included the word ‘compassionate’. In addition, it is explicit in the code of practice (NMC 2015). Clearly midwives have been directed to practise compassionately and require a clear understanding of what compassionate midwifery means. The assumption that compassionate midwifery is universally understood could cause confusion and thus have an impact on practice. To this end an analysis of the concept of compassionate midwifery was undertaken. Clarification of the evolving concept will contribute to improved understanding in the profession and provide a robust basis for practice and research. In this article, for ease of reading, the word ‘woman’ or ‘women’ will be used to refer to woman or women during the pregnancy, birth or the postnatal period.

### **Analysing Concepts**

A concept is not defined by its words alone; it is the idea or characteristics behind the words that reveal a concept (Rodgers 2000b). Watson (1979:49) described a concept as ‘a mental picture or image’ that ‘symbolises ideas and expresses an abstraction’. The purpose of a concept analysis is to identify consensus regarding that concept by understanding what meaning is attached to its use (Rodgers 2000a, Hupcey & Penrod 2005) to ascertain the level of maturity of the concept (Morse

2000). Several models have been widely used, although some, for example Walker and Avant's (2005) has been criticised for reflecting a fixed idea of what a concept is and is not (Rodgers 2000a, Chinn & Kramer 2011) rather than something that is constantly evolving.

The method of concept analysis used was adopted from Rodger's (2000a) and then adapted to use the original robust methodological procedure in a concise six step plan (Box 1). The main adaptation was that rather than presenting an exemplar or model case of the concept, the findings are depicted in a schematic representation or model. The six steps did not result in a particularly linear process. In common with Lackey's (2000) observations, at times the individual steps of concept analysis merged together as some features of the concept remained resistant to classification or clarification. The process was iterative and went back-and-forth through steps one to five as individual steps required revisiting frequently. This allowed data to be considered and re-considered as understanding developed.

## **Compassion**

The concept of compassionate midwifery uses the adjective 'compassionate' to describe a type of or aspect of midwifery practice. This analysis will first consider compassion before exploring the concept of compassionate midwifery

Compassion has been the source of debate and deliberation amongst philosophers, spiritual leaders, religious scholars, psychologists, neuroscientists, anthropologists and those concerned with moral and ethical studies (Goetz *et al.* 2010). Numerous definitions demonstrate different perspectives, but a consistent theme is recognition of and response to another's suffering. One of the most

confusing aspects of compassion is its relatedness to other emotions like empathy, sympathy and pity. Goetz *et al.* (2010) claim that although compassion can be seen as a distinct emotion it is part of a family of emotions that includes pity, sympathy and empathy. This was evident in a search for different definitions of compassion, of which there were many. **Table 1** represents a selection of these demonstrating slightly different perspectives and variations in emphasis.

Many definitions use other terms in the family of compassion-related emotions, either alone or in combinations to define compassion. This demands some understanding of the subtle similarities and differences between members of the compassion family. **Table 2** identifies these and lists the origins and the nature of each. This family includes pity, sympathy and empathy. Altruism is included as it is thought to be closely related to compassion (Batson & Shaw 1991) and also kindness, a word frequently used interchangeably with compassion (Goetz *et al.* and Youngson 2012).

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

## **DATA SOURCES**

Data collection was achieved through a search of Medline, Cinahl, PhychInfo and ETHOS using the search terms: compassion\* and also for other terms closely related to compassion: empath\*, kindness, emotion\*, relationship-based. Each of these were combined with each of the following: midwi\*, birth, childbirth, pregnan\*, maternity, antenatal, prenatal, antepartum, labour, intrapartum, postnatal, postpartum, neonatal, breastfeeding (to capture all areas where midwives may be practising). Limiters were set to the words or terms appearing in the title or abstract, English language and between 1990 and 2015. However, seminal work prior to 1990 was referred to when appropriate (e.g. during a hand search of any paper citing influential work). In addition data about the use of the concept in grey literature and everyday usage was sought using a Google search for ‘compassionate midwifery’ and setting a Google alert to monitor for new online content on the concept. A flow diagram of the search strategy and results is shown in [Figure 2](#). A large number of papers (3311) and other works were identified. Exclusions were made by title if there was no link to compassion or midwifery. Exclusions were made by abstract if there was no link to both compassion and midwifery, for example the term ‘birth’ was frequently used in ways that did not focus on childbirth. The remaining papers and other texts were read in full to consider relevance, focus and substance and eligible paper’s references hand searched for any new data. The final number of papers and other works was 73.

### **Data Management and Analysis**

All data were appraised and general findings and key themes noted.

Evolutionary concept analysis is an inductive, discovery approach to data analysis and focuses on using the data to identify the attributes and other contextual features of the concept (Rodgers 2000a). This process was a challenging one because the literature

search revealed a dearth of data dealing explicitly with compassion in midwifery. For this reason the practice of using a random selection of the data (Rodgers 2000a) was not followed and all the relevant data were used in an effort to ensure nothing was missed. Actual definitions or even explanations regarding compassionate midwifery were absent. Implied definitions and associations could be elicited by using Rodger's (2000b) technique of repeatedly going back and asking the question: What is this thing that the writer is discussing?

Although the data contained evidence of significant interest in and discussion around compassionate midwifery, explanation of its inherent meaning was missing and meaningful analysis or description was negligible. For this reason it was necessary to return to the compassion process (Figure 1) and take each of the four aspects of compassion: recognition (of suffering), emotion, motivation and action and identify how the gathered data mapped onto these. This time the information was forthcoming and the four areas were not only visible but they clearly revealed ways compassion is demonstrated in midwifery care.

## **Surrogate Terms, Scope, Attributes, Antecedents and Consequences of the Concept Compassionate Midwifery**

### ***Surrogate Terms***

Surrogate terms can be used in place of the concept. 'Compassionate maternity services' is a term that includes midwives and other professionals in the maternity care team. It was recognized that sometimes it may be impossible for women to

differentiate between different professionals involved in their care, therefore this was considered a surrogate term.

### *Scope*

Compassionate midwifery proved to be a broad concept covering a range of situations and related behaviours. The analysis suggested that it can be applied to a professional care encounter with a woman during pregnancy, childbirth or postnatal period and/or with her baby. It can also be applied to her birth partner or another member of her family or significant others and to the way a midwife cares for herself or her colleagues.

### *Attributes*

Attributes, antecedents and consequences are all shown in [Table 3](#). The primary goal of any concept analysis is the identification of its attributes as these amount to a real sense of the concept rather than a dictionary definition (Rodgers 2000a). By considering the different steps in the process of compassion ([Figure 1](#)) in relation to the data nine attributes were identified.

### *Antecedents*

Antecedents are what has to happen or be in place before a concept happens (Walker & Avant 2005). Suffering during pregnancy, birth or in the postnatal period can be seen as a primary antecedent because the midwife's recognition of suffering is

the first stage of the process. Several other themes emerged from the literature that were seen as fundamental to compassionate midwifery. These were different approaches, skills and resources necessary for midwifery to be practised compassionately.

Fear was identified as a threat to compassion and yet part of the environment where midwives work, therefore fearful midwifery could be considered as an antithesis to compassionate midwifery. There is no category for factors that counteract the concept in the model used. Therefore, low fear levels have been included as an antecedent.

### ***Consequences***

The consequences of compassionate midwifery were the aspects of the concept that were best supported in the literature. Although the data did not contain detailed descriptions of compassionate midwifery, it did reveal its desirability and benefits and how women have a need for it, therefore it was the consequences that were most easily identified

### ***Related Concepts***

Identifying related concepts assisted in understanding how the concept of compassionate midwifery fits with the network of concepts surrounding it (Walker & Avant 2005). The concepts that were found to be most closely aligned with compassion in the literature were identified as:



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

All four related concepts frequently appeared in the data in relation to compassion or aspects of compassion. One-to-one midwifery, continuity of midwifery care and midwife-led care all support and potentially strengthen the midwife/woman relationship (McCourt *et al.* 1998, Sandall *et al.* 2015, Walsh & Devane 2012).

Human rights in childbirth is related as it emphasises the rights of the individual and links compassionate maternity care to respect and women's autonomy (Prochaska 2015; White Ribbon Alliance 2013).

### **Mapping the data to the four elements of the compassion process**

#### ***Recognition of Suffering***

The recognition and alleviation of suffering is a key aspect of compassion. Suffering is not an obvious word of choice for midwifery, which seeks to empower women using positive terminology (Byrom 2013, Furber & Thomson 2010, Hunter, L. 2006). Neither is it entirely alien, given that in childbirth women are confronted with intense physical and emotional stressors (Simkin 1996) and that many women do report suffering and trauma related to childbirth (Coates *et al.* 2014) . Suffering is part of being human and it results from unacceptable physical and emotional changes, worries about the future or loss of autonomy (Cassell 1982, Davenport 2015, Sensky 2010). Arguably, suffering, in some form, must precede compassionate midwifery.

Several papers indicate that to recognise a woman's suffering a midwife must be available to her and have the sensitivity and skills to notice what is happening to her. Berg *et al.*'s (1996) phenomenological study found that above all women must feel the midwife's *presence*. One-to-one midwifery in labour has been associated with a range of improved birth outcomes (Hodnett *et al.* 2013) and is therefore considered best practice (NICE 2014) but it has not been universally achievable (Care Quality Commission (CQC) 2013). However, there is more to presence than physical presence. Hildingsson & Rådestad's (2005) study concluded that women want their midwife to pay close attention to them and to their partners. Berg *et al.* (1996) found that the midwife's presence incorporated treating the woman as an equal and with respect and also being in-tune with the woman and noticing her needs. She found that women can distinguish between midwives who are 'authentically present' and those who are 'absently present.' The midwife in the room but not noticing her needs or being emotionally available was considered absently present. This was also recognised in a systematic review of women's perceptions of breast-feeding support (Joanna Briggs Institute (JBI) 2012) that highlighted that authentic presence creates trust and connectedness between the woman and health care professional. Being truly present has been linked with spiritual care in midwifery (Hall 2013, Moloney & Gair 2015). This refers to the midwife respecting the special or sacred aspects of childbirth and its place in both a woman's life and the universe (Garratt 2001). Gaskin (2002) links compassion to the spiritual aspects of midwifery.

Hunter (2011) analysed midwives' poetry to interpret the experience of being with women during birth and identified that midwifery presence had several functions. These included keeping vigil, providing protection and safety, inspiring confidence in a woman's ability to birth or 'embodied power'. Others describe

midwifery presence as watching and waiting or 'holding a space' for a woman to birth (Evans 2012, Seibold *et al.* 2010).

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

### ***Emotion***

The data supported the view that emotional connection is highly valued by women and an important aspect of compassionate midwifery care. This is primarily expressed through empathic concern (Nikula *et al.* 2015, Raine *et al.* 2010, Wilde-Larsson *et al.* 2011). Empathy builds on recognition of suffering by seeking to understand the nature of the experience (Wiseman 1996). Women report feelings of vulnerability during childbirth (Simkin 2002) and describe a need for someone to be caring, kind and emotionally close to them (Halldorsdottir & Karlsdottir 1996).

Women want midwives to care **for** them but also care **about** them by entering into a warm and caring relationship (Howarth, Swain & Treharne 2012). Empathy is an important component of successful midwife/woman relationships (Moloney & Gair 2015; Seefat-van *et al.* 2011). Several studies have linked high quality midwife/woman relationships to increased trust and feelings of safety and security (Berg *et al.* 1996, Davison *et al.* 2015, JBI 2012, Williams *et al.* 2010). Although

midwife continuity supports the development of such relationships, many women are cared for in labour by a midwife they have never met. Several authors have pointed to the quality of the relationship being central to high quality care and satisfaction with care (Howarth *et al.* 2012, Kirkham 2010, Tinkler and Quinney 1998). Deery (2012) states that everything that midwives do connects to this relationship.

Several studies have investigated the emotional content of the woman/midwife relationship. John (2009) looked at emotion work between women and midwives during labour and established that women used emotional management techniques to relate to their midwives to make their birth experience more positive. Carter & Guittar (2014) found that birthing women need to process their emotions and this would sometimes be with their midwife. This emotional processing appears to be important throughout pregnancy and childbirth and offers some protection against postnatal depression (Wilkins 2012).

MacLellan (2014) noted the emotional and professional balancing act that midwives encounter in their work. Hunter (2006) studied the way community midwives cope with this emotional nature of their work using Hochschild's (1983) framework of emotional labour. Hochschild's (1983) seminal work with flight attendants identified two modes of emotional labour: the deep act that represents an authentic connection with another and a surface act used when there were difficulties with communication preventing deep connection, yet there was a requirement to maintain a 'professional face'. Professional norms and organisational rules have an impact on how carers act in their role (Huynh *et al.* 2008) Schmidt and Diestel's (2014) study with nurses revealed that surface acting (or work persona) was associated with job strain whereas deep acting (or authentic connection) was unrelated. Rayment (2015) and Hunter & Smith (2007) have called for more research

about emotion work in midwifery. The emotional intensity and high stress levels in modern maternity care settings suggest that compassionate midwifery needs to include self-compassion and be extended to colleagues (Deery 2014).

Emotional intelligence has been described by Patterson & Begley (2011) as ‘the ability to recognise our own feelings and those of others and it encompasses managing emotions effectively in ourselves and in our relationships’ and it is considered essential to empathy (Goleman 2004: 96). It is therefore an important characteristic for compassionate midwives. Emotional intelligence and self-awareness support relationship-based, compassionate care and improves midwives’ capacity to deal with pressures at work and increases job satisfaction (Sener *et al.* 2009). There have been calls for emotional intelligence to have a much higher profile in the recruitment and education of midwives (Patterson & Begley 2011, Hunter 2009).

### ***Motivation***

The compassion process can only progress to support and assist women with the alleviation of suffering by moving through an emotional response to a behavioural response or action. The motivation for midwives to alleviate suffering appears varied. A midwife may take action to assist a woman because it is seen as an inherent part of the role (Nolan *et al.* 2014). But this does not explain the experience of women who can clearly differentiate between midwives who take the time and trouble to assist them in appropriate ways and those who provide ‘standard care’ (Davison *et al.* 2015, JBI 2012). Knapp (2015) implores midwives to ensure that their familiarity with birth does not ‘translate into routine actions’ without ‘a core of passion and compassion’. Respectful, trusting, equal relationships place midwives in a position where they

genuinely want to empower women to have the best birth they can (Halldorsdottir & Karlsdottir 1996, Hermansson & Mårtensson 2011). This is also underpinned by principles, values and beliefs. For example there is growing interest and support for the principles of human rights in childbirth (Prochaska 2015). This movement seeks to address the feelings of vulnerability and powerlessness that can accompany pregnancy and birth and use human rights law to achieve autonomous, respectful and dignified maternity care (Birthrights ND).

Lack of motivation to act may be understood by examining circumstances where there is a serious lack of compassionate midwifery. Bohren *et al.*'s (2015) systematic review of the global mistreatment of women during childbirth, which spanned 34 countries, illustrated how childbirth experiences are marred by mistreatment including abusive, neglectful and disrespectful care. Women commonly reported 'mechanical care' and not receiving the attention they needed. Factors contributing to mistreatment include staff shortages, staff being overworked and underpaid, lack of training, lack of facilities and discrimination on the basis of race, socioeconomic status and medical condition. The review clearly demonstrates how organisational, situational, educational, personal and cultural factors all have an impact on the motivation and ability to provide compassionate care

Several authors have pointed to the increasing emphasis on risk in maternity services contributing to an environment of fear that midwives work in. Byrom & Downe (2015), Dahlen & Gutteridge (2015) and Kirkham (2015) all describe ways where a culture of fear has an impact on midwives' ability to be kind and compassionate. Fear of making an error, disapproval, recrimination, litigation, humiliation and possible loss of role and livelihood contributes to fearful working. Campling (2015) and Youngson (2012) have linked this trend to suppression of

compassion as fear becomes the dominant emotion. It is thus plausible that a climate of fear acts to stifle midwives' motivation to respond to women's suffering.

### ***Action***

Women need actual help and 'tangible support' as well as emotional care (Iliadou 2012, Nikula *et al.* 2015) and thus women need knowledgeable and skilful (as well as compassionate and kind) midwives (Goberna-Tricas *et al.* 2011, Nicholls & Webb 2006). Viewing midwifery as either practical or emotional is problematic when trying to understand compassionate midwifery because it creates a false separation. It is the combination of these two aspects that women value. Hill (2013) highlights the need for 'competent care with compassion and patience' when supporting women with perinatal addiction. However, this need is evident, not just in the most vulnerable women, but by women generally within the whole range of maternity provision (Halldorsdottir & Karlsdottir 1996, Tarkka *et al.* 2000, JBI 2012).

Midwives work in partnership with women when providing care and support (ICM 2011) and compassionate care happens in such partnerships. For example, a woman may request pain relief in labour. The midwife may respond by discussing various options for pain relief, explaining the advantages and disadvantages of different methods, thus facilitating informed choice while acting to help her manage her pain. The need to be able to communicate well to explain care options is supported in the literature (Raine *et al.* 2010, Nicholls & Webb 2006). Frohlich & Schram (2015) call for the communication of risks and choices to promote knowledge, understanding and respectful compassionate care. Failure to explain and inform in a balanced way leads to women feeling that they are removed from

decision-making and women describe the ill-effects of feeling that things were done to them rather than for them (MacLellan 2015). Similarly, The JBI (2012) noted that although women value practical care and support in relation to breastfeeding, the style and way information is shared and help is offered is important. Power sharing, alongside good communication skills are central to this.

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

### ***A Model of the Concept***

By using **Figure 1** as a framework and working through the method adapted from Rodgers (2000a) a concept analysis of compassionate midwifery has been developed and is shown in **Figure 3**. This model of the concept of compassionate midwifery incorporates the characteristics of the concept generated through data analysis. It demonstrates the scope, antecedents and consequences of the concept and organises the attributes of compassionate midwifery in the four phases of the



compassion process. Moreover, the attributes and their connections offer a definition of compassionate midwifery, which is: the interrelations of authentic presence, noticing suffering, empathy, connectedness/relationship, emotion work, motivation to help/support, empowering women and alleviating suffering through negotiation, knowledge and skills.

### **Limitations**

The most significant limitation was lack of data containing descriptions of compassionate midwifery. This supports the idea that it is still a new and evolving concept. This lack of maturity is not ideal in terms of the concept analysis process (Botes 2002) because the concept has not been clearly differentiated from other concepts. This was initially seen as a limitation. However, the concept of compassion is mature and as such it provided a way forward through a process of systematically relating the elements of compassion *to* midwifery. A range of literature was used in this process although for practical reasons only those in English were included and it is possible that relevant data were omitted because of this.

### **DISCUSSION**

This concept analysis facilitated deep emersion, exploration and clarification of this emerging concept. Although this is a valuable contribution to midwifery theory it would be premature to consider it a theory in itself because, as yet, women's voices are missing. There is cautiousness about theory development in midwifery, perhaps because it has not been associated with the identification of its own paradigms, grand

and middle-range theories to the extent that the nursing profession has (Cody 1999). Undoubtedly there is mounting evidence of a body of midwifery theory (Bryar & Sinclair 2011), however more work is needed to identify, strengthen and differentiate the professions knowledge base. This concept analysis supported the view that the way midwives demonstrate compassion in their practice is distinct and is associated with a particular set of attributes. This schematic representation of compassionate midwifery is a starting point from which a theory of compassionate midwifery can be developed.

## **CONCLUSION**

Midwives, educationalists, managers and policy makers will be better placed to ensure compassion in midwifery practice if they understand more about the meaning and experience of compassionate midwifery. This concept analysis is an important starting point in that process. The model can be used by midwives to reflect on their own practice and midwifery educationalists can use it when incorporating compassion into curricula and considering the links between compassion and other areas like communication skills, clinical competence and ethics. Feedback from these activities will be valuable in the development of the model.

Empirical studies provide the potential to take the process further by studying the experience of compassionate midwifery from several different perspectives. The model of compassionate midwifery will be developed and refined as new questions about compassionate midwifery are asked and studied. There might be several places to commence this process, for example, the midwife's experience or the influence of compassion on midwifery education or maternity policy. However, the lack of

research regarding how women experience compassionate midwifery care makes this a compelling starting point.

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Table 1: A Selection of Definitions of Compassion

| Author/Source and year            | Origins or type of work   | Definition  | Emotional response                               | Motivation for action                        | Other feature/s of note                                     |
|-----------------------------------|---|---|--|--|---|
| Collins English Dictionary (2015) | Dictionary  | 'feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it'   | yes  | yes  |   |
| Oxford Dictionaries (2015)        | Dictionary  | 'sympathetic pity and concern for the sufferings or misfortunes of others'  | yes  | no   |   |
| Taliaferro (2010)                 | Dictionary of Philosophy and Religion                               | 'Literally 'feeling with' a compassionate person is one who empathizes (or sympathizes) with those believed to be harmed and is disposed to go to their aid'.   | yes  | yes  |   |
| Jonas (2005)                      | Dictionary of Complementary and Alternative Medicine                | 'a profound awareness of another's suffering coupled with a desire to alleviate that suffering'   | Implied by 'profound awareness'                  | yes  |   |
| Youngson (2012)                   | Book: 'Time to Care'  | 'the humane quality of understanding suffering in others and wanting to do something about it'  | Not explicit, emphasis on understanding          | yes  | Identifies compassion as a 'humane quality'                 |
| Miller-Keane and O'Toole (2005)   | Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health | 'a virtue combining concepts such as sympathy, empathy, fellow feeling, benevolence, care, love, and sometimes pity and mercy. These are character traits that enable professionals to use their cognitive and psychomotor skills of healing to meet the needs of a particular patient. The need for particularity in the healing relationship makes compassion a moral virtue' | yes  | yes  | Character traits<br>Moral value                             |
| Gilbert (2009)                    | Book: 'The Compassionate Mind'                                      | 'a basic kindness, with a deep awareness of the suffering of oneself and other living things. Coupled with the wish and effort to relieve it.'  | Not explicit, emphasis on kindness and awareness | yes  | Includes self as well as all living things                  |
| Wikipedia (2015)                  | Online Encyclopaedia  | 'The response to the suffering of others that motivates a desire to help'.  | Not explicit                                     | yes  |   |
| Cummings and Bennett (2012)       | DoH Strategy  | 'Compassion is how care is given through relationships based on empathy, respect and dignity<br>- it can also be described as intelligent kindness, and is central to how people perceive their care'   | Yes  | Not explicit but implied; it relates to care | Relationship<br>Respect and dignity<br>Intelligent kindness |

Table 1: *A Selection of Definitions of Compassion*

Table 2: The Compassion Family of Emotions and Related Concepts

| word       | Origin*   | Definition**   | Sensitivity to suffering | Feels sorry for | Feels sorrow with | Motivated to alleviate suffering |
|------------|---|--|--------------------------|-----------------|-------------------|----------------------------------|
| Pity       | From 12th and 13th Century word. Old French and Latin <i>Pite, Pitet</i> and middle English <i>pity, piety</i>    | Feeling of sorrow for the suffering of another   | Yes                      | Yes             | No                | No                               |
| Sympathy   | From the Greek <i>Syn</i> (together) and <i>pathos</i> (feeling or suffering)                                     | Solidarity for another in their suffering  | Yes                      | Yes             | Yes               | No                               |
| Empathy    | From Greek <i>En</i> (in or at) and <i>pathos</i> (feeling or suffering) Translated to English in 1909            | The human quality of understanding the suffering of others                                 | Yes                      | Not necessarily | Not necessarily   | Not necessarily                  |
| Kindness   | From old English <i>gecynde</i> (with the feelings of family/kin) and Proto-Germanic <i>Kundjaz</i> (family/race) | The quality of being generous, considerate, friendly and deliberately doing good to others | Yes                      | Not necessarily | Not necessarily   | Yes                              |
| Altruism   | From old French and Latin meaning <i>of or to others</i>  | The principles and practice of concern for the welfare of others                           | Likely                   | Not necessarily | No necessarily    | Yes                              |
| Compassion | From late 12th century Latin means <i>feel together</i>   | The feeling that arises in witnessing another's suffering and the desire to help           | Yes                      | Not necessarily | Yes               | Yes                              |

\*Word origins in this table are informed by the Online Etymology Dictionary (2015)

\*\*Definitions for this table draw on a wide variety of dictionaries, texts and other examples of usage in an attempt to differentiate them



Table 3: Antecedents, Attributes and Consequences of Compassionate Midwifery

| Antecedents   | Attributes  | Consequences  |
|---|---|---|
| <p><b>Suffering/Distress (or potential for)</b> (Lyberg &amp; Severinsson 2010, Hall 2013, Coates et al 2014)</p> <p><b>Partnership approach to care</b> (Berg et al 1996, Hildingsson &amp; Radestad 2005, Cummings &amp; Bennett 2012, Campling 2015, Knapp 2015)</p> <p><b>Respect</b> (Berg et al 1996, Lyberg &amp; Severinsson 2010, Cummings &amp; Bennett 2012, Knapp 2015, Prochaska 2015)</p> <p><b>Non-judgemental approach</b> (Berg 1996, Scott 2015)</p> <p><b>Sensitivity to suffering/distress</b> (Berg 1996, Raine et al 2009)</p> <p><b>Emotional intelligence</b> (Patterson &amp; Begley 2011, Deery 2012, Hall 2013, Campling 2015)</p> <p><b>Listening and communication skills</b> (Nicholls &amp; Webb 2006, Raine et al 2009, Campling 2015, Kirkham 2015, Scott 2015)</p> <p><b>Competence in midwifery skills which may alleviate/prevent suffering/distress</b> (Tarkka 2000, Nicholls &amp; Webb 2009, Kirkham 2010, Hall 2013)</p> <p><b>Time and appropriate resources</b> (Kirkham 2010, JBI 2012)</p> <p><b>Low fear/anxiety levels (midwife)</b> (John 2009, Deery 2014, Dahlen &amp; Gutteridge 2015, Byrom &amp; Downe 2015)</p> | <p><b>Authentic presence</b> (Berg 1996, Wilde-Larsson et al 2011, Deery 2012, JBI 2012)</p> <p><b>Noticing suffering/distress</b> (John 2009, Cooper 2015)</p> <p><b>Empathy</b> (Raine et al 2009, Goberna-Tricas 2011, Cummings and Bennett 2012, JBI 2012, Hall 2013, Knapp 2014)</p> <p><b>Connectedness/relationship</b> (Cummings &amp; Bennet 2012, Deery 2012, Hall 2013, Campling 2015, Dahlen &amp; Gutteridge 2015, Davison et al 2015)</p> <p><b>Engaging in emotional work</b> (Hunter 2006, Hunter 2009, Deery 2012, Byrom 2015, Campling 2015)</p> <p><b>Motivation to help or support</b> (Wile-Larsson et al 2011, Hall 2013)</p> <p><b>Seeks to empower the woman</b> (Hallsdordottir &amp; Karlsdottir 1996, Walsh &amp; Devane 2012)</p> <p><b>Negotiating ways to alleviate/prevent suffering/distress through shared decision making</b> (Berg 1996, Lyberg &amp; Severinsson 2010, Frohlich &amp; Schram 2015, Knapp 2015, Scott 2015)</p> <p><b>Using knowledge and skills to alleviate/prevent suffering/distress in a way that is welcomed</b> ( Nicholls and Webb 2009, JBI 2012, Knapp 2015)</p> | <p><b>Trust between Woman/Midwife</b> (Berg 1006, Lyberg &amp; Severinsson 2010, Dahlberg &amp; Aune 2013, Campling 2015)</p> <p><b>Maternal Satisfaction</b> (Williams et al 2010, Carter &amp; Guitar 2014, Campling 2015, Moloney &amp; Gair 2015)</p> <p><b>Reduced fear of childbirth</b> (Hallsdordottir &amp; Karlsdottir 1996, Lyberg &amp; Severinsson 2010, Howarth et al 2012, Campling 2015)</p> <p><b>Women feel sense of control/ empowered</b> (Hallsdordottir &amp; Karlsdottir 1996, Hildingsson &amp; Radestad 2005, Moloney &amp; Gair 2015, Prochaska 2015, Scott 2015)</p> <p><b>Improved birth and postnatal outcomes</b> (Walsh &amp; Devane 2012, Hodnett et al 2013, Carter &amp; Guittar 2014)</p> <p><b>Positive birth experiences and birth memories</b> (Tarkka et al 200, Howarth et al 2012, Carter &amp; Guittar 2014)</p> <p><b>Reduced PND and reduced PTSD</b> ( Wilkins 2012, Moloney &amp; Gair 2015, Knapp 2015)</p> <p><b>Improved job satisfaction for midwives</b> (Hunter B 2006, Scotland 2014)</p> <p><b>Better working relationships/ team work</b> (Patterson &amp; Begley 2011, Walsh &amp; Devane 2012)</p> <p><b>Impact on health and wellbeing of midwife</b> (Hunter B 2006, Deery 2012, Walsh &amp; Devine, Deery 2014, Sheen et al 2014)</p> |

Figure 1: Model of the Process of Compassion

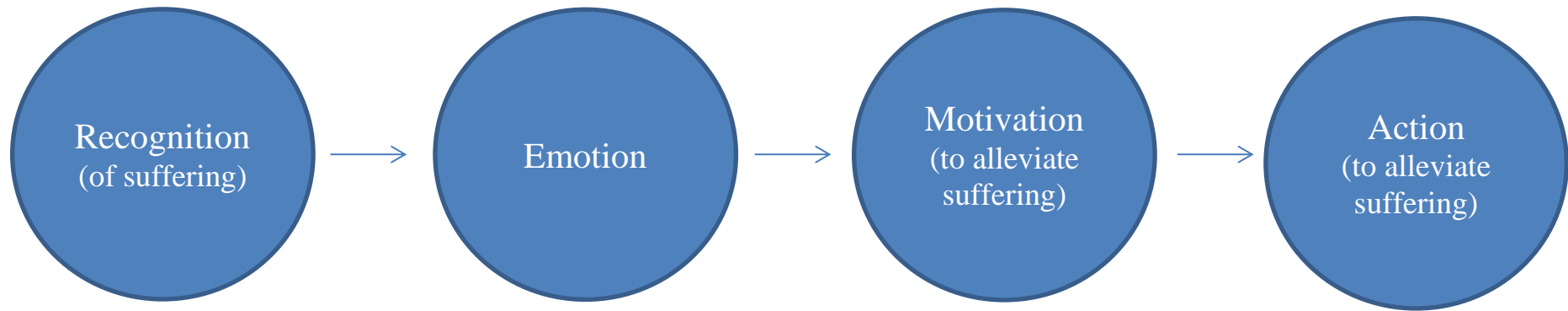
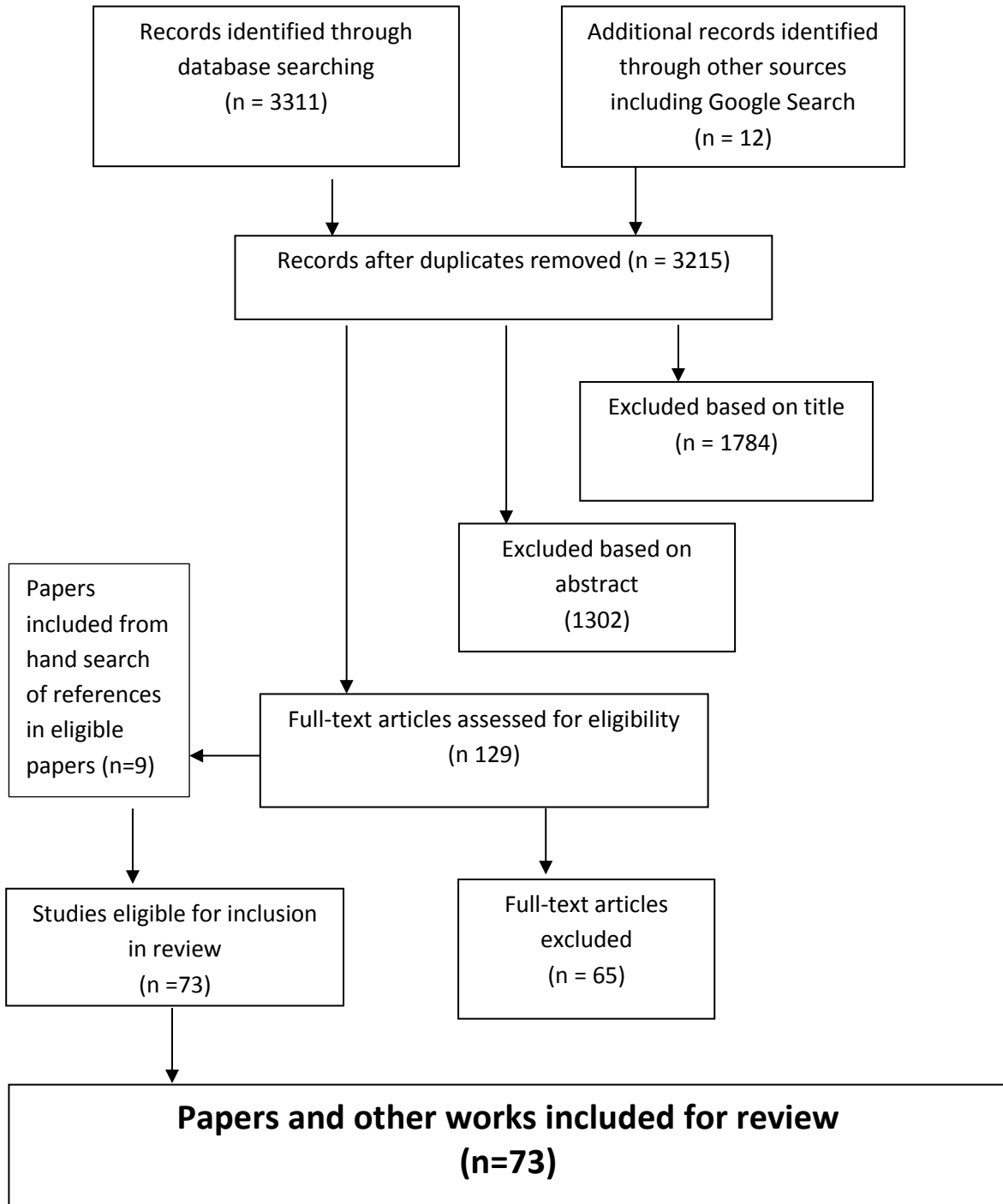


Figure 2

Results of the search strategy for a concept analysis on compassionate midwifery



Reasons for exclusions:  
no relevance to midwifery, not related to compassion, not substantial

**Figure 3**  
**Model of the Concept of Compassionate Midwifery**



**Scope:** a professional care encounter between a midwife and a woman during pregnancy, childbirth or postnatal period and/or with her baby, birth partner/significant others. It may also refer to the way midwives care for themselves or for colleagues

Box 1: Method for Concept Analysis adapted from Rodgers (Rodgers 2000a)

|   |   |
|---|---|
| 1 | Identify and name the concept of interest                                 |
| 2 | Data Collection   |
| 3 | Identify surrogate terms and relevant uses of the word                    |
| 4 | Identify the scope, attributes, antecedents, consequences of the concept  |
| 5 | Identify related concepts   |
| 6 | Develop a model or schematic representation of the concept if appropriate |