Title Dignity and Respect in Midwifery Education in the UK: a survey of Lead Midwives of Education

ABSTRACT

In the UK respect, dignity and compassion are the underpinning values which must determine service user care in the National Health Service (NHS). In midwifery education it is unclear how students are being taught these values. We created a study that aimed to explore how learning about dignity and respect is facilitated and assessed within pre-registration midwifery curricula. An online survey was devised and distributed to all Lead Midwives for Education in the UK. The findings are presented under the three main themes of understanding the meaning of dignity and respect, teaching and assessment and experiences. The study concludes that, though there are some good areas of education practice there is inconsistency in how Nursing and Midwifery Council (NMC) guidelines are transferred into curricula. This leads to students receiving differing emphasis of education on the values of dignity and respect.

KEYWORDS

Dignity, respect, midwifery education, survey

HIGHLIGHTS

- It is unclear what providing care that promotes dignity means in midwifery education.
- There is lack of consensus of how learning about dignity is facilitated or assessed.

- Students are receiving differing emphasis of education on the values of dignity and respect.

INTRODUCTION

In the UK respect, dignity and compassion are the underpinning values which must determine service user care as outlined by the NHS Constitution (Department of Health (DH) 2013). The Department of Health (2013) and the NMC (2015) are unambiguous in their declaration that patients and services users must be cared for with dignity and respect. Respect for human dignity is also the underpinning philosophy of the International Confederation of Midwives (ICM 2014) Yet recent national and international concerns have been raised which illustrate that too often service users receive care that falls below this standard (DH 2012a, The Mid Staffordshire NHS Foundation Trust Inquiry 2013, Birthrights 2013, Kirkup 2015, White Ribbon Alliance 2011). Promotion of dignity in healthcare includes concepts of respect, empathy and individualised care (Goodman 2013). The Royal College of Nursing (RCN) provides a useful definition when considering promoting dignity in care:

'*Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.'*(RCN 2008).

The indication is that dignity and respect are entwined. From a midwifery perspective there is expectation that concepts of dignity and respect are included in the UK Chief Nurses' campaign to increase compassionate care in nursing and midwifery (6 Cs programme) (Hall 2013). *The campaign for respectful* care has also received an

international focus (White Ribbon Alliance 2011, Freedman and Kruk 2014, Bohren et al 2015). The White Ribbon Alliance (2011) place considerable emphasis on the role of interpersonal relationships in providing respectful care. However, globally there is a lack of consensus of what consists of respectful care in midwifery practice (Vogel et al 2015).

Pregnancy and childbirth are a time of immense change in women's lives and many women report feelings of vulnerability and of being on an 'emotional rollercoaster' (DH 2011). Many women are fearful of birth and the pain of labour. This coupled with often the need for intimate examinations by professionals' demands highly skilled and sensitive care. The quality of care experienced by women during pregnancy and birth may affect emotional wellbeing. Pregnancy and childbirth can be experienced as empowering, healing particularly when the quality of care is individualised, reassuring, and emotionally supportive (Moberg 2015). However, research confirms that many women describe their encounters with midwives as uncaring (Eliasson et al 2008, Bowser and Hill 2010, Bohren et al 2015). A recent survey identified that women in the UK do not always feel that they have been treated with dignity and respect during their birth experience (Birthrights 2013). Additionally, Morad et al (2013) found in a recent audit of one NHS Trust that complaints from women highlighted the care they received lacked compassion, empathy, and emotional support. A number of complaints also related to midwives demonstrating a lack of courtesy and rudeness. There can be no excuses for such behaviour but some suggest that the ability of health care professionals to provide care that promotes dignity and is respectful is compromised by over medicalisation, administrative overload and the organisation structure which detracts from continuity of care and leads to stress and burn-out (Morad et al 2013). It is well documented that workplace

stress can lead to ‘burn-out’ resulting is substandard care and, in the extreme, unsafe care (Schaufeli, Leiter and Maslach, 2009, Boorman, 2009). Women appear to accept without question the loss of their dignity during birth yet we argue that this does not need to be the case and midwives and students should be educated to ensure that providing dignified care is the norm.

In these challenging times, it is essential that staff receive appropriate support and education in how to deliver care that respects service user’s individual needs and aims to maintain their dignity at all times. However, dignity and respect are complex and multifactorial concepts and thus difficult to teach or learn about in a formal way (Goodman 2013). There is a call for more effective education around these concepts, with identification on how they can be learnt and assessed in health professionals (Birthrights 2013). There is a lack of educational initiatives to enhance the teaching and learning of the core values of dignity and respect. The RCN’s (2008) work pack which aims to promote dignity and respect was evaluated with nursing staff and found to stimulate reflection on how promotion of dignity could be improved in practice. However, no such initiatives are reported in the education of student midwives.

As midwifery educators, we are concerned to explore how we can best prepare student midwives to protect dignity and provide respectful care to all women and their families. The NMC Standards for Preregistration Midwifery Education (2009:39) states that all student midwives must ‘treat women with dignity and respect them as individuals’ but no direction is given for how students should be prepared. There is currently no consensus of what these terms mean within a midwifery context or how learning around dignity and respect for student midwives can be facilitated.

For the purpose of this paper, the term ‘dignity’ or ‘care that promotes dignity’ will be used and will include ‘respect’ and ‘respectful care’ unless required to be otherwise.

RESEARCH AIM

The aim of the study was to explore how learning about dignity and care that promotes dignity, is facilitated and assessed within pre-registration midwifery curricula.

RESEARCH METHODS

An online survey was devised with 8 open ended questions to elicit information on: midwifery educator’s understanding of dignity in midwifery care, how learning about dignity is included and assessed in midwifery curricula, midwifery educator’s experiences of facilitating learning about dignity and examples of innovative ways of teaching and assessing about dignity. A total population sample of Lead Midwives for Education (LME) in each Higher Education Institution (HEI) in the UK (n=58) were invited to participate. The response rate was 21% (n=13). Although the questions provided opportunity for extensive answers some of the answers were expressed succinctly we therefore chose to use content analysis to interpret the findings. This was carried out by both authors independently, jointly tabulated and cross checked to confirm interpretation and presentation of the findings. The findings are presented under the three main headings: understanding of the meaning of dignity and respect, teaching and assessment strategies and educator experiences. Confidentiality and anonymity were guaranteed to respondents. Ethics approval was given by the University of the West of England, Bristol, Ethics Committee.

1. UNDERSTANDING OF THE MEANING OF DIGNITY AND RESPECT.

Participants were invited to write in a free space their understanding of the terms dignity and respect. Seven respondents referred to dignity and respect as integral to each other.

> *'Respect and dignity are synonymous and is about recognising that all people are equal and valuing individual values, beliefs and preferences'.* (R8)

Others gave broad definitions for both, yet also indicated the links between them. For example,

> *'Respect for dignity is in terms of maintaining an individual's self-worth. Respect is in terms of treating someone as an individual, thereby maintaining their dignity and enabling choices' (R13)*

The responses above highlight respect for the individuality of the person while also recognising their worth as human beings. These concepts are not alien to midwifery practice where it is expected care should be 'women-centred' and 'individualised' (National Collaborating Centre for Women's and Children's Health (NCCWCH) (UK) 2008).

Concepts of dignity and respect were described by participants in a number of ways i.e. as a specific way of caring, as recognising personhood of others and as essential as intrinsic values for midwifery practice.

1.1 A specific way of caring

The respondents' made suggestions of how to promote dignity including *'understanding people's personal needs and values* (3)'. The term '*treating others in*

a way you would wish to be treated' (1,6) was referred to more than once, along with '*treating all people with 'intelligent kindness*'' (5). The respondents mentioned that care promoting dignity ensures the needs of a person are met. For example, respondent 2 listed:

> *'meeting a woman's needs for information, privacy, hygiene, cultural and religious needs.'*

The need to ensure privacy in midwifery practice was also seen as essential by others:

> *'dignity means protecting privacy being aware of the intrusive nature of some midwifery procedures and activities and the impact they may have on women and adapting care accordingly.'* (R4)

It was also highlighted the quality of the relationship between women and midwives is fundamental to promoting dignity but that these relationships require *'time to listen and care'* (R11)

. *'relationships which are built on trust and understanding of each other.' (*R4)

1.2 Recognising the value of personhood

The respondents clearly identified that care promoting dignity involves recognition of the value of the individual as 'being of worth', such as '*ensuring that they feel valued, that their view counts*' (R6) and that we '*value their contribution to society'* (R7). In recognising human value there were comments regarding 'equal care':

> *Respect & dignity …. is about recognising that all people are equal & valuing individual values, beliefs & preferences (R8)*

There were also statements that highlighted the cultural diversity of our society:

> *Respect is about dealing with diversity and people who have ideas and preferences different from your own* (R4)

Care that promotes dignity therefore is regarded as individual to the person and equal '*irrespective of gender, sexuality, class, race, culture, and beliefs'* (R11).

1.3 Intrinsic values for midwifery practice

The respondents indicated that dignity is an expected aspect of midwifery care. For example, respondent 10 stated:

> *'Dignity and respect are intrinsic within the holistic care for women - they are the foundation for respectful midwifery are which should be the professional demeanour of all midwives. Respectful midwifery care includes choice, control, person-centred care, women at the heart of their care, women coming first'.*

Midwives are also expected to be '*non-judgmental'* (R1) and '*avoiding embarrassment or upset…being kind, caring, polite* (R2) and to '*show good manners* (R2). There is also expectation to treat:

> *'women, families and all colleagues and the public we meet with the utmost courtesy, understanding, genuine interest' (R11).*

Participant 10 indicated this *is 'part of professionalism'* with the midwife as an *'advocate for women'.* Respondent 3 also indicated that the role of the midwife in advocacy and promoting women's autonomy was central in promoting dignity:

'about saying no to interventions and procedures when others are trying to override this and having the communication skills to do this regardless of circumstance.'

Such statements are not surprising as these values of practice are embedded in midwives Code of Practice in the UK (NMC 2015). However, it is not always evidenced in midwifery practice as highlighted in some reports (Birthrights 2013).

2. TEACHING AND ASSESSMENT

In the questionnaire, participants were invited to share where the teaching and assessing of dignity was situated in their midwifery curricula and how this was facilitated. The findings explored here relates teaching and assessment strategies.

2.1 Programme Content

We asked the respondents for information relating to learning outcomes (LOs) of their current midwifery programmes to establish how far the principles of dignity are in the midwifery curriculum. Four respondents provided specific LOs in answer to the request, (R 1, 6, 9, 13). Six of the responses stated that the outcomes included both theory and practice (R 1, 3, 4, 6, 9, 13). The LO's covered three main themes including professional behaviour (R 1,9) recognising the individual (R 6,13) and recognising diversity (R 1, 6, 13).

However, two respondents indicated no LOs were specific to dignity, although one stated it was taught, but *'linked in with* '*equality and diversity'* (R 11). The other indicated:

> *'Module learning outcomes encompass the NMC Competencies and Essential Skills Clusters, where they refer to dignity and respect'. (R5).*

Overall, there was no consensus on which programme LOs match with the development of promoting dignity and of meeting the NMC (2009) Standards.

All responders indicated that the teaching of dignity is included in some way in the undergraduate midwifery programme. Most considered these as fundamental concepts in the education of student midwives.

> *'Integral to the whole programme - weaved through all topics/ discussions /teaching to highlight how centrally important these issues are to all midwifery care'*. (R10)

Several responses also identified that particular emphasis on these concepts occurs in specific modules both practice and theoretical:

> '*It is alluded to in all modules - especially so in a level 6: 'Valuing Individual Cultures' module* (R7)

> '*They are integral to the whole programme but are more obviously prominent in the practice based modules*. (R 5)

One respondent indicated recent additional input into the teaching of dignity. It is pleasing to note this responsiveness to national imperatives.

> *'this year we have included specific teaching sessions in relation to compassionate care/respectful care/person-centred care due to the national focus on these issues'*. (R 8)

One respondent also indicated that dignity permeated all practices within the teaching facility and was mirrored '*in the support provided to the students'* (R 4). Student learning is influenced by the values and cultures exhibited both formally and informally

by organisations. When appropriate values and attributes are role modelled in teaching practices and in relationships between student and staff in educational facilities this contributes to the positive development of these attributes in the nurses and midwives of the future (Del Prato 2013, Baldwin et al 2014).

2:2 Methods used to facilitate learning on dignity and respect.

It appears that a wide variety of interactive methods are used to promote student learning about dignity. Commonplace classroom activities including core lectures, small group work, use of scenarios and discussion, video clips, problem based learning were cited frequently. There were some examples of blended learning approaches with the use of online study packs.

> *'Core lectures and small group work to explore meaning of privacy and respect, online learning and teachings resources'* (R9)

Only one respondent indicated the use of national resources such as provided by Compassionate Connections programme and the Spirituality Matters Handbook (NHS Education for Scotland (2009) to aid learning. This may be as a result of the limited resources available for education across the NHS. However, there were also some examples of innovative teaching and learning methods including 'role play', 'plays where student write the dialogue', and 'verbatim reporting'(R2). A method known as 'speed dating' was described:

> 'speed dating is used to discuss earliest memories of different people - e.g. teenagers, mental illness, substance misuser, religion, ethnicity etc. Values based assessment & flashcards pertaining to stereotypes are used' (R8)

This seems a useful strategy given that self-awareness and reflection on personal values is essential in learning how to care (Youngson 2015).

Two respondents specifically highlighted how learning about dignity is facilitated via student practice experiences:

> '*Students attend an observational elective. They formatively present their experiences. The summative assessment is a poster presentation in which student have to … Critically analyse how cultural, spiritual, political, legal, social, economic and environmental factors can affect/impacts on care…* (R 8)

Nine respondents indicated that academic midwifery lecturers were the main health professional to facilitate learning about dignity in the midwifery curriculum. Two respondents mentioned that other health care professional such as nurses, and mental health nurses also facilitated learning on these concepts.

Midwife clinical practitioners also contributed to teaching and respondent 6 reported that a specialist 'bereavement midwife' and the 'supervisor of midwife' contributed to the teaching of these topics. The chaplain was mentioned by one respondent and service users by 4 respondents as having specific input. The contributions of other educators may serve to reinforce the message and give valuable insight to students.

There was little acknowledgement of the role of practice mentors in teaching about these concepts: Respondent 7 was the only one to specifically mention practice sign off mentors as facilitating learning.

> 'Practice outcomes are assessed by mentors and supported by evidence and discussed with link tutor'*(R7).*

There seems to be untapped resources for facilitating learning about dignity and respect. When service users are involved in education of students learning is enhanced as students feel the emotions of service users and experience a connection with those they care for (Mitchell and Catron 2005, Terry 2012).

2.3 Assessment strategies

Most respondents also indicated that the students were assessed in line with the NMC essential skills clusters that promote dignity. Assessment of these attributes took place mainly in practice as a pass or fail (R 1, 4, 5, 10, 12).

> '*They are assessed through assessment in placement by sign-off mentors and at the end of year tripartite assessment (student, mentor and link-tutor)'* (R4).

One response also stated students would receive a grade in the assessment of these attributes.

> '*Current programme has a professional attitude scale in the clinical portfolio that notes dignity and respect. Student and mentor completes this at each clinical placement and it forms part of the summative clinical assessment'*. (R 5)

Examples were also given for how aspects around dignity were assessed in theory modules:

> '*Dignity and respect are also aspects of the OSCE marking grids for the Breastfeeding and the Obstetric Emergencies OSCEs*'. (R 5)

‘*Assessed via an essay, within skills tests, problem based learning.* (R6).

More worryingly other responses seemed to indicate that the assessment of student’s learning about dignity only occurred in an informal manner, for example, through the setting of ‘ground rules’ (R 7), or by mentors commenting on student performance (R9)

> *‘whilst we do not have specific learning outcomes achievement of the NMC competencies and a ward report completed by mentors identify if problems exist. Classroom behaviour is also monitored by the year tutor/award leader*. (R 2)

One respondent noted that the assessment of dignity was ‘not applicable’ although had stated previously teaching on the subject was included in the programme (R 8).

From the above responses it is apparent in most situations dignity is assessed both in theory and practice in a variety of ways. In practice some students will be graded on these attributes whilst for others they would constitute a pass or fail. Student midwives’ ability to provide care that promotes dignity is also assessed both formally and informally through academic assessments and by classroom behaviour.

3. EXPERIENCES AND CHALLENGES IN FACILITATING LEARNING

For many of the responders their experience of facilitating learning about dignity was positive, for example:

> *I don't find it challenging at all - it is integral to the very people we are and whom we strive to develop in our students* (R 9)

> *Extremely supportive environment in the School and real promotion of dignity, respect as well as equality and diversity issues* (R 11)

This experience appears to have been enabled by a supportive University environment. A positive culture was also evidenced in the values of the midwifery teaching team:

> *The teaching team here believes in leading by example and not just teaching about dignity and respect, but LIVING in such a way that exudes dignity and respect*. (R5)

It was further present in the values of the educators themselves:

> *Sharing how being kind and connected with women matters. Being respectful of all contributions and valuing each other's contribution. Adopting an approach of unconditional positive regard throughout* (R 6).

However, there were concerns that this culture was not evident in some clinical settings. For example, the quote below suggests that for students the achievement of clinical skills is prioritised over their ability to provide care that promotes dignity as this is seen as a '*softer skill'.*

> *Our experiences to date have been very positive in the academic setting. Until such times as these priorities are matched by the priorities of the clinical setting it will continue to be seen as a 'softer' skill in comparison to resuscitation, cannulation, HDU and the like!* (R 3).

Further concerns were expressed at the negative responses to the subject by some of students and staff:

concepts viewed by staff and students as not as important as some other topic areas - (R 4)

everyone in the group comes with pre-conceived ideas about the topic. Some students also think this is not a subject which needs to be taught and can be quite negative about the topic. (R12)

It also appears some educators may not be fully equipped or confident in dealing with personal issues that often arise for students when learning about promoting dignity,

sometimes this may reveal (teachers) *discomfort in dealing with challenging issues in the classroom (R4)*

Others also associated the perceived lack of time to facilitate an exploration of the subject more deeply:

Time can be difficult to give more to these topics. Not all students appreciate the need to have lessons as they do not understand the importance of the topics - frequently complain that it is repeated (R 2).

The education team may see the need for increased input and repeated inclusion of the subject of promoting dignity, but the students find it less important, presumably in comparison to other subjects they see as more relevant.

However, overall respondents felt positive about the teaching of dignity, they highlighted some challenges in ensuring it is embedded in the programme.

DISCUSSION

The aim of this survey was to establish how, across the HEI curricula in the UK, facilitation of learning around the concepts of dignity and respect for midwifery practice

is taking place. The study illustrates there is currently little consensus or consistency in undergraduate midwifery education programmes.

For respondents the concepts of dignity and respect are entwined and inseparable. They are considered to be a way of caring for women that is both important and relevant for their well-being. The person is valued as central to the care, and they also recognised that the values embedded in promoting dignity is an expected standard for being a midwife, integral to the personhood of midwives. Such values are embedded globally within expectations for midwifery (ICM 2013). This supports the contemporary drivers toward 'values – based' selection processes, where students are to be chosen with characteristics of caring and compassion (Waugh et al 2014, Fry et al 2013, Rankin 2013, Tetley et al 2015). Such methods of selection are subjective and, as yet, untested and we argue that students will still require education practices to reflect promotion of dignity in order for this to be applied within contemporary midwifery.

In this study, the midwives' role in advocating for women in supporting promotion of their dignity is acknowledged. The midwife as protector of a woman's dignity through advocacy is recognised in the NMC Code (2015:5) and international competencies for midwifery practice (ICM 2013). This indicates the midwife's role of being 'alongside' women supporting their choices (Lucas 2011) and is a powerful aspect of the midwife/mother relationship. In order for this to be effective appropriate attitudes around promoting dignity would be required. Thus students need to be prepared for this role, to understand accountability (Lucas 2011) and develop assertiveness in order to challenge others' behaviours (Warland, McKellar & Diaz 2014). Students must also understand what constitutes appropriate care to promote dignity in order to recognise where standards fall short.

Overall, respondents recognised that promotion of dignity should be an expected part of the curriculum. However, some were unable to identify any specific learning outcomes or assessment strategy. Assessing professional human values, however is recognised to be a challenge (Bradshaw 2009). The NMC Essential Skills Clusters (ESC's) (2009) outline the skills students are expected to achieve on midwifery programmes in the UK. It is arguable whether the mere presence of dignity in the ESC as a word is enough to ensure students develop adequate learning to ensure quality of care is given or whether more focussed education is required. In addition, a one off assessment is not sufficient to ensure maintenance of these skills (Benner 1982). Assessment of student's ability to provide care which promotes dignity should require evidence of an ongoing process of development. The lack of consistency of outcomes illustrates the lack of consensus over what should be within curricula and therefore the difference in expectation for student midwives to achieve across the country, and no doubt, globally. Midwifery curricula based on NMC Standards (2009) and the ICM (2013) international standards are accountable to the profession, the public and consumers and must demonstrate that midwives of the future are educated to deliver care that promotes dignity and is respectful to everyone.

Respondents to the study included some innovative classroom activities but detail was often lacking. There is currently little evidence for midwifery educators to explore how best to equip students to provide care to promote dignity; however, learning is possible from other health care professionals who grapple with the same issues. Adam and Taylor (2014) argue educational strategies should encourage students to invest emotionally in their learning. They suggest an approach that supports nursing students

to reflect on challenging aspects of cultivating effective relationships with relatives or patients. In collaboration with course tutors, students develop a personal 'toolkit' of methods to help them meet their individual learning needs. In their evaluation of this approach there is suggestion students were empowered to nurse with more compassion (Adam & Taylor 2014).

The suggestion from respondent 5 that despite there being no actual 'teaching session' the midwifery lecturers are modelling the values in how they teach and in all sessions as well as 'living in such a way that exudes dignity and respect' is commendable. Students have much contact with academics; therefore, they must view their role as more than educators of theoretical knowledge. Del Prato (2013) found that educators who modelled professional values contributed positively to the development of such values in students. Baldwin et al (2014) argue that academic role models have a 'powerful' effect on student learning but there is little evidence to support this for midwifery education and further research is warranted. In the study is indication that where a culture of promoting dignity is present within Faculty the staff in turn feel supported in addressing these issues with students. Evidence shows that the wellbeing of staff is essential to the work place and quality programmes (Carter & Evans 2013, Doherty 2014, Oswald et al 2014). This is in clear contrast in a culture where staff are not valued (Gillen et al 2009).

The suggestion is that promotion of dignity may be learned from observing practices and behaviours of others. There is some evidence that students cite 'good role models' as essential to their learning best practice (Baldwin et al 2014) and that they will further absorb the learning they receive through socialisation (Parsons & Griffiths 2007). Students learn most clinical care alongside midwifery mentors ~~and learn~~ and mirror clinical behaviours (Armstrong 2009). Mentors are 'gatekeepers' to the students'

learning and success leads to them wanting to ‘fit-in’ to the system (Yearley 1999) and adjust their behaviour accordingly. Therefore, a further area of research could explore mentors understanding of promotion of dignity in care as this would demonstrate how students are influenced within the practice environment. Additionally, research on the perceptions of students on the education they are receiving and the need for education around the promotion of dignity would provide valuable insight.

The study highlighted a discrepancy between academic and practice expectations. It is concerning that, some respondents were unable to demonstrate how competency for promotion of dignity was achieved in practice as this is where students should be developing their attitudes and values as midwives of the future. The emphasis in some clinical practice environments means priority is placed on the development of students’ clinical skills rather than on developing a more holistic woman centred approach. Butler et al (2008) identified that essential competencies for midwives include effective communication, clinical skills, and appropriate values and attitudes. Such competencies may be more effectively developed through models where students carry their own case-loads and develop relationships with women. Indeed, the latest review of maternity services in the UK recommends that continuity of care where care is based on relationship of trust, support and women’s choices are respected is more likely to achieve safe and effective care (Cumberledge 2016).

There is agreement that respect for the dignity of people is intrinsic to the values of midwifery as a profession. However, it is acknowledged how this translates to practice is more challenging given that the interpretation of what is considered dignified respectful care maybe different between and within cultures (Allan and Davidson 2013). It is suggested that educators can learn from the developing world (McConville

2014). The White Ribbon Alliance has developed a range of resources including a Respectful Midwifery Care charter, a graphic film and a role play devised by midwives. Examples are cited of how quality care is improved when these resources were used to facilitate learning about dignity. The use of approaches which focus on experiential learning, the use of real–life scenarios, visual metaphors and critical reflection and continual reinforcement of these values throughout the curriculum are also suggested as best practice (Dewar 2012, Gallagher 2012, Goodman 2013, Branch 2015). Two respondents also referred to the role of service users in facilitating learning. A considerable body of evidence supports service user involvement in education of health professionals (Mitchell and Catron 2005, McKeown et al 2015). The NMC (2009) also includes a standard for preregistration midwifery education that highlights the value of involving service users in all aspects of the curriculum. Service user involvement that includes a balance of perspective may contribute to the development of students as professionals and can take many forms.

The compassionate care strategy (DH 2012b) highlighted here will be drawing to a close soon and it is unclear where this leaves education and practice. It is unknown if it will be evaluated long-term to demonstrate its relevance or impact. The measurement of its success will be a challenge if the values are not reflected and reinforced within education or practice for the students. Within the current cultures of UK midwifery individualised women centred care is expected which recognises dignity and cultural nuances thus valuing the individual. This is endorsed through expectation that women should receive care that is respectful and compassionate, that she is in control and listened to with carers obtaining informed consent (National Collaborating Centre for Women's and Children's Health 2014:34), and that she should be central in decisions

(NHS England 2016). In order to provide this there needs to be organisational cultural change (McCormack et al 2015).

It is recognised from this small study that, for student midwives, current education in the UK related to providing dignified care is mixed. It is evident that more work needs to be carried out to establish the best ways to facilitate learning for student midwives that reflects current practice. Such learning may also be required for qualified midwives to remind them of the need to care in a respectful manner. Within our department, we created workshops around dignity that appears to be beneficial to enable students to recognise the need for promotion of dignity. It was also carried out in a setting for qualified midwives and other health care providers with similar responses. Information around this will be presented in a subsequent paper.

Limitations

We recognise this was a small survey of the Lead Midwife educators across the Higher Education institutes in the UK, not all of whom responded. This therefore may not be applicable to other countries. However, there may be some similarities of the way that an individual curriculum may not always reflect the national strategies or be individual to the particular organisation or educators concerned.

This methodology meant that provision of qualitative answers tended to be brief and a future study could involve face-to-face interviews for more depth. The study does however provide a valuable ‘snap-shot’ of some of the issues in relation to education of student midwives around this subject.

We recognise too that the response rate was less than half of the HEI’ in the UK. We have reflected whether there would have been more responses to a ‘paper-based’

questionnaire, than via the internet, due to some educators having challenges in accessing some online platforms. We have also reflected on whether the questions were hard to answer. However, having carried out a pilot of the study, we did not think this was a particular issue. The lack of responses does mean that it is therefore not clear whether students in other institutions are all receiving education on the topics or none of them is.

Conclusion

The study does highlight that more discussion needs to take place across all the organisations to establish how the NMC guidelines are transferred into curricula. Lack of consensus means that individual HEI are focussing on different aspects of the guidance as important meaning that students will be getting different emphasis of education. Poor links in certain practice areas and recognition of the joint aspects of the programme reinforce the theory-practice gap that has been present for many years. The study concludes that, though there are some good areas of education practice there is inconsistency in how current education guidelines are transferred into curricula. This leads to students receiving differing emphasis of education on the values of dignity and respect

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