

Footprints of Birth: an innovative educational intervention foregrounding women's voices to improve empathy and reflective practice in maternity care

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Empathy and reflective practice in maternity care

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Conflict of interest and source of funding

AL is on the Board of Directors of the International MotherBaby Childbirth Organisation. LV, LN, AS, TB none declared.

Institutional Ethics Approval

The service improvement project was considered exempt from the need for formal ethical approval by UCL (University College London) Research Ethics Committee and NHS (National Health Service) Health Research Authority. (Please see attachments.)

Acknowledgements

We would like to acknowledge the efforts of the team that developed the Footprints of Birth documentary who are Amma Kyei Mensah, Richard Megroff, Toni Harman.

Introduction

A global movement on Respectful Maternity Care has arisen due to widespread accounts of dehumanised maternity care. This article considers the use of a transformative learning approach to highlight patient agency and personhood in healthcare. An educational intervention using patient narratives was introduced in a maternity unit to foster a culture of listening and responsiveness to women's voices. This article reports the impact on staff and student learning, empathy and reflective practice.

Methods

A total of 245 interprofessional providers participated in 14 workshops over a 16-month period. Participants represented a range of health professions including medicine, midwifery, nursing and allied professions. Senior management, administrators and peer support volunteers also attended. Session sizes ranged from 5 to 60 attendees. The format included documentary-style videos of patient feedback followed by audience discussion. Discussion points were collected and qualitatively analyzed for participants' critical reflection, emotional engagement, cognitive dissonance and perspective transformation.

Results

Learners reflected on the client-caregiver relationship and care provision. Staff and students showed empathy for the women sharing their stories. Learners were disturbed by failings in care and wished to improve services. All provider groups highlighted the importance of communication, compassion and patient autonomy as key elements of maternity care.

Discussion

Multi-professional learners engaged emotionally with women's narratives and reflected critically on their roles in maternity care. Learners' responses showed evidence of transformative learning. Staff and students recognised the value of providing respectful, empathic care. Educational interventions highlighting patients' voices may promote patient autonomy by reducing dehumanisation in healthcare.

Key words

autonomy, care, communication, empathy, maternity, reflective practice, respect, values

Patient-centred care is the international standard of healthcare, placing the individual patient's needs, preferences, concerns and values at the heart of decision making.¹⁻⁴

An essential prerequisite of patient-centredness is compassion,⁵⁻⁸ defined as:

*“the sensitivity shown in order to understand another person's suffering, combined with a willingness to help and to promote the wellbeing of that person, in order to find a solution to their situation”.*⁹

The importance of compassion in healthcare training and practice is being increasingly recognised, partly in response to a culture of neglectful provider-patient relationships. Lack of compassion and human rights violations have been observed across a variety of international healthcare settings, resulting in harrowing and life-changing consequences.¹⁰⁻¹³ There is global recognition of the need to safeguard standards of Respectful Maternity Care which humanises women and upholds women's rights and autonomy.¹⁴⁻¹⁷

Haque and Waytz proposed a conceptual framework for dehumanisation in healthcare, accounting for why 'caregivers may treat patients less like persons, and more like objects or non-human animals'.¹⁸ They noted that causes included: (a) deindividuating practices within healthcare, (b) the perception of patients as having impaired agency, (c) a sense of dissimilarity between the professional and patient, (d) treating people as mechanical systems, (e) empathy reduction, and (f) moral disengagement. These processes act to undermine the philosophy of care which frames the patient as an autonomous individual at the centre of decision making. Haque and Waytz suggested that dehumanisation can be addressed by adopting practices that emphasise the personhood and agency of patients, recognise the importance of empathy, and highlight similarities between patients and professionals.¹⁸

Research has found that workplaces valuing the expression of emotion and compassion not only develop compassionate care, but enable staff resilience to handle the emotional burden of the work.⁵ Educational interventions that include poor examples of care as well as honest, emotionally-engaged self-appraisal, strengthen resilience and support 'transformative learning'.¹⁹⁻²¹ The theory of transformative learning describes a process involving critical reflection and challenge to one's beliefs in order to promote a fundamental perspective change. This process can be unsettling for learners, who may experience 'disorientation' and discomfort. It is particularly enhanced by a supportive learning community in which learners engage collaboratively in discourse, questioning underlying assumptions to stimulate change.¹⁹⁻²¹ As transformative learning encourages a re-evaluation of one's values, attitudes, and behaviour, it is highly relevant to educational interventions aiming to foster culture change in healthcare teams. It is for these reasons that we decided to generate a project aimed at improving compassion, empathy and an awareness of human rights in maternity care through the use of women's voices, captured as 'video selfies' about the care that they received.

Patient feedback is often collected routinely with the aim of improving care, but a key challenge is eliciting the issues which matter most to patients.²² Structured approaches to feedback, such as patient experience surveys, often focus more on aspects of services that are 'easy targets' to change, rather than core elements of care, such as clinician behaviour.²² Less structured approaches to capturing feedback, such as video recording patients, have been used to enable people to tell their stories about healthcare in their own words. This medium can be more emotionally powerful to watch and encourages staff engagement with service improvement.²³ However, whilst patient video feedback has been used to identify

aspects of services in need of change, little attention has been paid to how these video testimonials alter providers' perceptions of patients and their own professional roles in delivering care. Video may highlight the personhood of patients in a way that written feedback cannot. Direct access to patients' voices and perspectives of care may emphasise patient agency. Humanising patients and enabling providers to see care from the user's perspective may create a 'disorienting dilemma' for learners. This is an important catalyst for perspective transformation, as it requires learners to re-evaluate their assumptions and beliefs in order to resolve the discrepancy between their existing perspective and new information.^{20,21} This study took a unique approach to exploring the impact of patient video feedback by considering its effect on provider perspectives of maternity care.

In this article, we describe the evaluation of a multidisciplinary service improvement project based at the Whittington Health NHS Trust Maternity Unit, United Kingdom. The Whittington's mission values (ICARE: innovation, compassion, accountability, respect and excellence) state that the institution will work to support patients in being active partners in their own care.²⁴ As a maternity care facility, we had not previously identified any endemic cultural themes of dehumanised care. However, as part of our (ICARE) philosophy to promote a culture of listening and responsiveness, we evaluated an educational intervention designed to highlight women's narratives about their experiences of maternity care. Specifically, the intervention aimed to enhance empathy, compassion and reflective practice, through foregrounding women's perspectives of care and emphasising the personhood and agency of women accessing maternity services.

Methods

Setting

The maternity unit is situated within a United Kingdom public hospital (National Health Service) in inner city London. It provides free care to approximately 4,000 women per year. The population includes both socio-economically deprived and affluent patients, with diversity in nationality, ethnic background, sexual orientation and disability. The multidisciplinary staff at the unit reflects the population diversity. The setting is an academic medical centre that is affiliated with two local universities and provides training for medical students and student midwives. The unit comprises inpatient areas (antenatal, labour ward, birth centre and postnatal ward) and outpatient areas (antenatal clinic, maternity assessment and fetal medicine), as well as providing community midwifery services, and is supported by a neonatal unit.

Intervention

The educational workshop, entitled 'Footprints of Birth', was designed as an intervention to promote service improvement for staff and students across all professional disciplines in maternity care.²⁵ The workshop centred around a documentary comprising self-filmed video clips, submitted by maternity service users to the project website. Women were asked to provide 'video selfies' from their own smart phones or other digital devices of up to three minutes responding to the question: "If you had the chance to reveal to your healthcare provider, information that you would be shy, hesitant, cautious or have longed to make known about your pregnancy and experience, that would educate health care professionals and make them better able to care for pregnant women, what would you say to them?" All respondents completed an electronic consent form prior to video submission, giving written permission to include their video in a multi-disciplinary healthcare education

intervention. The videos were not observed by any of the project team before submission. Twenty-two videos were received, comprising a total duration of 75 minutes. These were reviewed by a multi-disciplinary staff team, whose comments were used to select clips for the 30-minute documentary, including both positive and negative feedback.²⁵ Technical editing and video production was conducted by Alto Films. In the final version, 18 women's responses were included: four were excluded due to repetition of themes, poor technical quality and discussion of healthcare unrelated to the maternity service.

The workshop was designed as a one-hour session, as this was the standard teaching unit for all learner groups. A pragmatic decision was taken to allocate half the time to the documentary to enable sufficient exposure to the range of patient narratives and time for private reflection and group discussion. After viewing the documentary in its entirety, learners were encouraged to reflect independently in order to conduct self-examination of their responses and emotions. Learners were asked to write short notes under the headings of 'thoughts', 'feelings' and 'opinions'. The headings were not further defined for the learners, but were chosen to prompt learners to reflect intellectually and emotionally without restricting responses to predefined topics. The facilitator encouraged open discussion for learners to share their reactions and perspectives. This included exploring learners' distress in response to the patient narratives, prompting learners to acknowledge a shared sense of discomfort and encouraging learners to collaborate to generate solutions. This method was chosen based on the authors' experiences of teaching diverse health professional staff and students, with the aim of fostering reflection and a sense of ownership and control within the team for service quality.²⁶⁻²⁷

After participants' short notes had been collected, at the end of the workshop the facilitator provided additional information, where relevant to the group's discussion. This included information about human rights in healthcare, workplace behaviours, resilience and/or leadership. This was included, for example, to respond to queries about addressing burnout or in response to perceived helplessness to change the system. A short 4-minute video was also shown (after the workshop) of responses from senior management and clinical leadership, describing their reactions to the women's narratives and service changes implemented. This was introduced after piloting the session, when learners had requested information about how the institution had heard and acted upon the women's stories.

Procedure

The workshop was run within the hospital at staff training days and student tutorials, and at two national conferences. Multi-professional staff and students participated in 14 workshops held over 16 months (Table 1).

Table 1 about here

Participants' short notes were collected from each session, transcribed and collated by participant group.

Ethics

This service improvement project was considered exempt from the need for formal ethical approval by UCL (University College London) Research Ethics Committee and NHS (National Health Service) Health Research Authority.

Analysis

An inductive qualitative approach was used to explore the themes arising from the learning, to enable meaning to emerge from the data without imposing preconceived categories.²⁸ The body of transcribed data was read in its entirety by two

researchers (AS and LN), who independently identified themes and sub-categories within themes through an iterative process. The final set of themes arising was agreed by consensus by four researchers (AS, LN, LvL, AL). One researcher (AS) allocated each of the participants' responses to the sub-themes; this was checked by a second researcher (LN) to resolve any discrepancies. When the entire data-set was organised by themes, participant groups were compared for the themes they raised and congruence in their perspectives on each topic. The final analysis was reviewed and agreed by four researchers (AS, LN, LvL, AL).

Results

The dominant themes arising from the learners' responses were critical reflections on: (a) the clinical relationship and (b) provision of care (Table 2).

Table 2 about here

Reflection on the clinical relationship

The dynamics of the professional-patient interaction was a key theme found in all groups. Four sub-themes were identified: communication and sharing information, compassion and empathy, respectful care promoting patient autonomy, and emotional responses to women's stories (Table 3).

Table 3 about here

Communication and sharing information

The impact of communication on the women's experiences of care was explored by all groups, who appreciated that being informed provided comfort and reassurance. It was noted that anxiety was caused by waiting for updates and explanations, and ineffective communication. Five groups (maternity staff, multi-disciplinary team, doctors, student midwives and breastfeeding peer support volunteers) noted that effective communication supported joint decision making. The importance of

continuity in care, as well as the need to be approachable and accessible, was raised by the multi-disciplinary team and doctor groups. Effective communication among professionals, including smooth handovers, was raised by maternity staff and doctors.

Maternity staff and project launch attendees noted the importance of avoiding assumptions about a woman's knowledge, and strategies to support effective information sharing (e.g. through using simple language and checking understanding). All groups recognised poor communication as a key service failing. Groups cited workload, understaffing and clinical uncertainty as obstacles to communication.

Compassion and empathy

The value attributed by women to the human, emotional aspect of interactions with professionals was recognised by all participant groups, with the doctor and midwife groups noting that patients prioritised care over clinical skills. Participants reported surprise that patients in the documentary clearly valued kindness more than the words used in providers' communication.

All the groups explored the impact of lack of compassion, and consequent fear and anxiety. Reflecting on examples of compassionate care, participants noted the value of approaches where the professional provided support 'above and beyond' their standard role, as well as displays of simple acts of compassion. Recognition that small signals make a big difference to women was apparent (doctor, multi-disciplinary team, medical student and student midwife), such as touch or holding a woman's hand. Despite recognising the priority patients give to compassion, doctors presented conflicting views about whether compassionate care was 'part of the job description' or 'beyond the standard role'.

Participants not only explored the concepts of empathy and compassionate care, but displayed empathy through their understanding of the patients' perspectives. The consideration for how women ought to be treated during clinical encounters signalled an appreciation of the value of compassion at both cognitive and emotional levels.

Respectful care promoting patient autonomy

Participants discussed human rights and respect for autonomy, which were noted as having considerable overlap with effective communication and compassionate care. All groups comprising healthcare staff or students considered their role in promoting women's autonomy, highlighting the importance of asking and listening. Doctor and medical student groups also reflected on conflicts between medical and patient agendas, and the need to balance these demands. These two groups, as well as the breastfeeding peer support volunteers, cited an example where a woman's decision was ignored, focusing on the importance of listening and respecting the woman's choices. Both the doctors and breastfeeding peer support volunteers noted that it was not enough just to *involve* the woman in her own care, but that the woman needed to be at the *centre* of her own care.

The breastfeeding peer support group described the culture of maternity care as an inevitable barrier to patient autonomy, suggesting that the 'institutionalisation' of birth has inherently taken control away from women.

The issue of consent, specifically about procedures, was discussed by doctors, medical students and breastfeeding peer support volunteers. The doctors reflected on the need to *ask* rather than *tell* the woman before a procedure, and both the doctor and medical student groups recognised the imperative of fully informed consent and the fundamental requirement of honesty.

Emotional responses to women's stories

Positive reactions to the examples of good practice were evident in the project launch, maternity staff and multi-disciplinary team groups, who displayed pride, pleasure and appreciation. Narratives describing poor clinical practice elicited negative emotional responses, particularly expressed sadness, from the project launch, multi-disciplinary team, medical student and student midwives groups.

Participants reacted with alarm to one patient's story, where she described that she had almost died, acknowledging how this emphasised the 'high stakes' to the individual and their family. Both the medical student and breastfeeding support volunteer groups expressed surprise and dismay at women's narratives describing procedures conducted without consent. The multi-disciplinary team and student midwife groups expressed discomfort in response to hearing women describe poor quality care. Medical participants were shocked that some of the women said they preferred to be cared for by midwives rather than doctors, due to the care and emotional support they received.

Some defensive responses and sensitivity were evident: some participants had not expected that women would be critical of the care they had received. Maternity staff and medical students both alluded to women's unrealistically high expectations. Medical students attributed failings in staff practice to the 'difficult system' in which they observed staff practising.

Reflection on care provision

Sub-themes related to (a) the influence of the wider healthcare context, determined by the standards and delivery of the National Health Service, and (b) local service practicalities and environment (Table 4).

Table 4 about here

Influence of the wider healthcare context

Most groups recognised the impact of operational deficits on the individual patient. Doctors, maternity staff, medical students, student midwives and project launch attendees highlighted an overstretched health service, with shortages of staff, services and facilities. The doctor, maternity staff and medical student groups recognised that women were aware of understaffing, understanding the impact on staff workload. Whilst the impact of staff shortages and time constraints was considered by maternity staff, medical students and student midwives, the maternity staff demonstrated pride in their ability to work effectively despite increased pressures. In contrast, medical students expressed apprehension over their future ability to cope in this system.

The importance of coordination and continuity of services in delivering safe and effective care was raised by the doctor, maternity staff and medical student groups. Medical students suggested patient advocates might be introduced and maternity staff suggested one-to-one care. The doctors also highlighted the importance of accessibility to services and to the team.

Local service practicalities and environment

The doctor, maternity staff and multi-disciplinary groups considered the environment and routines of the maternity ward, particularly noise levels. The doctors also mentioned lack of privacy, reception staff with their backs toward women, lack of seating and food quality. The doctor and multi-disciplinary groups both noted that postnatal ward routines and 'rules' could be stressful to women. The multi-disciplinary group suggested practical solutions, such as a 'welcome pack'.

Discussion

Reports addressing significant failures of care in the United Kingdom have led to recommendations that patient feedback should result in 'effective and implemented learning'.^{10,11} This educational intervention based on patient video feedback provoked the critical reflection, cognitive dissonance and emotional discomfort that characterises transformative learning, providing the conditions to facilitate perspective change.^{20,21} The intervention prompted participants to reflect on how staff behaviours and local practices enact the values of healthcare, and may promote or inhibit respectful, compassionate care that facilitates a woman's autonomy. Although listening to women's feedback resulted in participants experiencing negative emotions, this is an important process in motivating change. Participants showed disorientation, expressed as surprise, shock and alarm, as they realised that their views about care were not congruent with patients'. By using the discomfort engendered by the women's stories productively, participants were motivated to engage in creative problem-solving to identify viable solutions, generating a responsiveness in service provision. This included a focus on specific actions and a re-conceptualisation of roles and relationships. Learners mentioned specific practical strategies to improve communication and facilitate patient autonomy. Also at the more fundamental level of the provider-patient relationship, learners became aware of the central importance women placed on kindness, and 'care' on an emotional level, not just in the biomedical sense. This was particularly 'disorienting' for medical professionals, on discovering that they were not the preferred provider of care for this reason. Learners also recognised that patient autonomy was the core of the provider-professional relationship, and cannot be sidelined by the day-to-day pressures of a busy clinical setting. The learning environment also exposed conflict

between patient and professional agendas, with participants displaying insight into their role in negotiating this balance.

The use of video 'selfies' highlighted the personhood of women accessing maternity care, reducing the psychological caregiver-patient distance. This promoted learning at an emotional level through enhancing empathy and an increased awareness of the psychological impact of care. Responses to the intervention showed evidence of a reversal of the dehumanising culture.¹⁸

Groups including staff connected to the service discussed in the documentary were also more likely to express positive responses such as pride which positively reinforces good practice.^{29,30} The emotional responses thus serve the purpose of motivating meaningful change from those responsible for provision, as well as exposing future healthcare practitioners to a culture which is open and responsive to patient needs. Acknowledging that one's day-to-day professional practice requires change is difficult, and can leave staff feeling vulnerable or unvalued, but the presence of trusting relationships among learners is a key enabler of transformative learning.^{20,21} This aligns with extensive evidence-base that a mutually supportive ethos, engendering trust and psychological safety, is central to effective teamwork.^{31,32} The learner groups manifested a supportive team climate in the discussion, that was congruent with the unit's culture. This form of intervention may be less successful where the team dynamic is unstable, or if the group discussion is inexpertly facilitated.

A key emergent theme was the effect of the intervention in prompting critical appraisal of provider-patient communication. Participants reflected on the consequences of ineffective communication for quality of care, the psychological impact on women, and implications for women's human rights. Staff recognised the

role of communication in supporting informed decision making and respecting women's choices. This aligns with research and educational guidance highlighting the central role of communication in clinical practice.^{7,8,33} Across healthcare, poor communication is known to correlate with patient dissatisfaction, complaints and litigation, which can be prevented through effective communication which supports shared decision making.³⁴

Compared to communication, compassion receives less attention in modern healthcare curricula, despite continual recognition of its importance in practice.⁶ The workshops enabled participants to hear directly from women about the value they placed on compassion in maternity care. It was evident that participants were moved by the women's stories, and they demonstrated empathic insight into women's experiences. Encouraged to recognise patients' humanity, participants responded to the patient feedback on a deeper level, consistent with transformative learning. Factors relating to the wider healthcare context increase the pressure on healthcare professionals to control their work environment in such a way that reduces the opportunity for compassionate care.^{6,35} Participants highlighted the impact of staff shortages, increasing workload and lack of time on care. Although it was recognised that 'small acts of kindness' could be adopted without a significant cost to time, some participants suggested that women had high expectations and that this mode of caring was 'above and beyond' their standard role. These latter opinions are consistent with previous research suggesting that caregivers view compassionate care as an investment of energy and emotional resilience, with the cost compounded by working within a culture which does not value it.³⁶ For these participants, the dissonance between women's narratives and the health professional's philosophy of care remains unresolved, a limitation of single-session educational interventions.

The response to problems with the physical environment and culture was more uniform, transcending from identification of failures to the development of solutions. Many workshops contained staff members in strategic leadership roles with the power to enact these local changes at a service level. For participant groups associated with the maternity service, this reinforced the staff agency in facilitating improvements. Learner groups were visibly motivated by the intervention to make changes to the service, both at the level of their individual interactions with women and at the level of the system and procedures within the maternity unit. This consistent response from learners had prompted pilot groups to request the reactions of senior management and clinical leads. The video compilation of these reactions provided a focus for exploring how the entire service could enact change, with participants highlighting the value of the support of hospital and unit leadership. Although our intervention and evaluation may not be generalisable to other maternity units, other maternity services could replicate the learning experience to determine if similar key themes emerge. The principle of using women's voices to transform and improve professional behaviour may prove valuable in other settings. Other units could tailor such projects to their own infrastructural, technical and demographic background.

Conclusion

The need for consistently Respectful Maternity Care which supports patient autonomy is internationally recognised.¹⁴⁻¹⁷ In this article we have evaluated an innovative educational intervention using patient narratives in video form to highlight the personhood and agency of women providing feedback about maternity care. Systematic examination of participants' responses during the educational

intervention using a robust method of thematic analysis revealed evidence of critical reflection and emotional engagement in the learning, which prompted learners to focus on the values of healthcare and women's human rights. Learners' reflections on the importance of empathy, compassion and communication showed how the intervention acted to humanise service users, facilitating the perspective change required for transformative learning and a reversal of dehumanisation.^{18,20,21} We hope that more healthcare providers will be inspired to utilise the stories of patients to drive education, professional development, and local service improvements using the Footprints of Birth model.

Lessons for practice

1. Creating a transformative learning environment stimulates reflection and encourages healthcare professionals to prioritize patient-centred, compassionate care.
2. Learning experiences that elicit participants' emotional responses and cognitive dissonance motivate them to evaluate patient care practices and identify solutions.
3. Transformative learning sessions can expose broader systems issues and support the need for overarching organizational policies and culture change.

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Table 1. Workshop participants

Participant group	Training context	Number of sessions	Number of participants per session	Total
Launch attendees: Mixed: midwives, other healthcare professionals, students, participating members of the public, hospital Trust board members and National Health Service leadership	Project launch	1	30	30
Maternity staff: midwives, nurses, health care assistants, maternity support workers	In-service training	3	20	60
Multi-disciplinary team: Mixed: midwives, obstetricians, paediatricians, nurses, healthcare assistants	Perinatal interdepartmental multi-disciplinary team meeting	1	30	30

Doctors		2	5-10	15
1. Junior doctors	1. In-service training			
2. Obstetric and gynaecology consultants and junior doctors	2. Optional workshop at the Royal College of Obstetricians and Gynaecologists' conference			
Medical students	Scheduled teaching	5	10	50
Student midwives	Scheduled teaching	1	30	30
Breastfeeding peer support volunteers	National conference for breastfeeding peer support (La Leche League GB)	1	30	30
Total		14		245

Table 2. Themes arising from participant responses to the intervention

Theme	Sub-themes
a. Reflection on the clinical relationship	Communication and sharing information Compassion and empathy Respectful care promoting patient autonomy Emotional responses to women's stories
b. Reflection on care provision	Influence of the wider healthcare context Local service practicalities and environment

Table 3. Examples of reflection on the clinical relationship

Quotes	Participant group
Communication and sharing information	
<i>“As a team we are very good at caring but better communication is needed.”</i>	Maternity staff
<i>“Communication will make experience better to inform and reassure new mothers.”</i>	Student midwife
<i>“Use of clear plain language and more inclusion of women in plan of care.”</i>	Maternity staff
<i>“Important to be approachable and to give required information.”</i>	Doctor
<i>“Lack of certainty, comfort and security when a woman sees a lot of healthcare professionals who give different information.”</i>	Doctor
<i>“Negative feelings were around the negative communication. Being talked to in a cold way and just talked at.”</i>	Breastfeeding peer support volunteer
<i>“Lack of communication seems the most negative but can be fixed.”</i>	Launch attendee
Compassion and empathy	
<i>“Can’t put a value on empathy and compassion. The woman recognised that this is above the standard role.”</i>	Doctor
<i>“Some women felt warm, calm, supported.”</i>	Doctor
<i>“It makes you realise how small acts of kindness have such a huge impact on their experience and perception.”</i>	Student midwife

<i>“Manner’ very important – mentioned more often than ‘skills’.”</i>	Doctor
<i>“It saddened me that individual staff can spoil the birth experience if they don’t display empathy.”</i>	Breastfeeding peer support volunteer
<i>“Emotional film – women were emotional which makes me emotional.”</i>	Maternity staff

Respectful care promoting patient autonomy

<i>“More inclusion of women in plan of care.”</i>	Maternity staff
<i>“Take women’s needs on board.”</i>	Launch attendee
<i>“Trust the instinct of women. Once a decision is made, don’t ask... ‘Are you sure?’”</i>	Breastfeeding peer support volunteer
<i>“It’s heartbreaking that sweeps were done without informed consent or that a woman who had a strong desire for an upright birth was subsequently forced onto her back.”</i>	Breastfeeding peer support volunteer
<i>“Shocking that at one point consent was not obtained.”</i>	Medical student
<i>“They must be truthful in consenting patients, patients can sense honesty in consenting.”</i>	Medical student

Emotional responses to women’s stories

<i>“Good to hear all the positives and proud to be part of the team.”</i>	Launch attendee
<i>“I was really moved by the reports of compassion and caring by the midwives.”</i>	Doctor
<i>“Painfully honest in parts.”</i>	Student midwife
<i>“Brings bad feelings of my birth and triggers empathy and tears.”</i>	Breastfeeding peer support volunteer

“Even though the unit can be busy, understaffing is not an excuse for some staff behaviours.” Medical student

Table 4. Examples of reflection on care provision

Quotes	Participant group
Influence of the wider healthcare context	
<i>“Cracks in the system show under pressure.”</i>	Medical student
<i>“Disillusioned about staffing levels and lack of empathy by management.”</i>	Maternity staff
<i>“Feeling that you can’t ask because they are already busy.”</i>	Doctor
<i>“It hit home how much effort I put into my work, how little time there is to be with women and how hard it is to prioritise and balance women’s needs with midwifery responsibilities.”</i>	Maternity staff
<i>“Staff are at breaking point but still manage to give women the care they desire.”</i>	Maternity staff
<i>“Continuity of care is vital.”</i>	Medical student
<i>“Felt good bonding as saw same midwife.”</i>	Doctor
Local service practicalities and environment	
<i>“Noisy ward which wears women out.”</i>	Doctor
<i>“Interesting feedback re partners staying the night on postnatal ward and the disturbance (talking, snoring!) this can cause others.”</i>	Doctor
<i>“Rules that aren’t patient-friendly. Set mealtimes and 6 a.m. blood pressure checks.”</i>	Doctor