Original Manuscript

Nursing Ethics
2020, Vol. 27(3) 887–897
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The compassion levels of midwives working in the delivery room

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Abstract

Background: Compassion-based practices in midwifery are the most important expression of the depth of care quality. This concept is insufficiently represented in literature, therefore, studies on this subject are of utmost importance.

Objectives: This study aims to determine the levels of compassion of midwives working in the delivery room and the factors affecting these levels. The study was carried out in Kocaeli, Turkey.

Methods: This descriptive study was carried out from 1 February to 15 April 2019 in delivery rooms of six different hospitals located in the provincial centre of Kocaeli, Turkey, with 78 actively working midwives. Data were collected using a 'Compassion Scale' and analysed using the Mann–Whitney U test, the Kruskal–Wallis H test and the Spearman correlation test.

Ethical considerations: This study was conducted according to ethical scientific guidelines.

Results: The compassion score of the midwives were found to be 4.19 ± 0.39. The total compassion score was affected by professional factors such as number of patients, alternating shift work, number of traumatic births and work satisfaction. While the kindness subscores decreased depending on shift work and number of traumatic births, it was determined that the midwives who were satisfied with their work had higher kindness scores than those who were not. Also, as the age and professional experience of the midwives and the number of traumatic births increased, their indifference score also increased. Midwives who reported that they were not satisfied with their job had higher scores regarding separation and disengagement scores than those who were satisfied with their job.

Conclusion: It was determined that the compassion levels of midwives were found to be negatively affected by factors such as age, professional experience, job satisfaction and number of monthly traumatic births in a month. They should be reminded that compassionate midwifery care for women is a basic human right.

Keywords

Compassion levels, midwives, ethics, professional factors

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Introduction

The concept of 'women-centered' care is at the centre of midwifery. Many studies state that the partnership developed between the woman giving birth and the midwife not only yields positive results for the mother and child but also increases the midwife's job satisfaction and motivation.[1,2] This unique and empathetic relationship between the midwife and the woman can reach higher levels with the midwife's compassionate approach.[2] Caesarean sections rates have increased in recent years. In order to reverse this trend, Turkey has developed a state policy to support normal birth and made large investments to enable midwifery and professional prosperity during and after their education. The main purpose of this effort is to enable the midwife to support a normal pregnancy and birth, pay attention to care and detail, respect the woman's uniqueness and to maintain an attentive care.[3] To further address this process, relevant efforts are important to support midwifery care with midwifery values. This study aims to determine the levels of compassion of midwives working in the delivery room and the factors that affect these levels.

Background

The subject of compassion has been discussed among philosophers, spiritual and religious scholars, psychologists, neuroscientists, anthropologists and those interested in moral and ethical work.[4–6] The concept of compassion, based on many authors' definitions, can be defined as the deep realization of someone else's trauma or pain.[7] Compassion differs from love, empathy, sympathy or pity as the person wants to act against the negative situation. In other words, when one witnesses the physical or emotional suffering or pain of another, that person will take action to help motivated by compassion.[4,6–8] The concept of compassion has an intense theological background. It is a principle taught by all major world religions.[6] For example, according to the Qur'an, it is the sense of pity in humans that leads them to be compassionate about the problems of other humans and living creatures and is the reason why they want to help. The compassion-oriented sense of religion also stands out in the Bible. In this context, it is frequently said that God is compassionate and that people need to be compassionate too. The Torah and Psalter also stated that God has an endless compassion. In a sense, compassion is an important source.[9,10] It is an important value that makes it easier for health professionals to provide patients with care and health professionals are expected to own this value.[8] Communication based on respect, honour and compassion increases patient satisfaction and the quality of healthcare.[11] Studies are still being conducted to develop strategies to ensure that compassion remains central to healthcare in midwifery.[4] In addition to the efforts to protect and increase this value, the number of studies on compassion in nurses has also increased in recent years.[12–14] Compassion and the related concepts has become even more important in all professions that require spending longer times with patients. Many international organizations related to midwifery[15–17] state that mercy is at the centre of midwifery care.[18,19] The International Confederation of Midwives (ICM) calls for midwifery care based on compassion, honour and human rights.[20] Another example of the increase in the emphasis on compassionate midwifery in recent years is the definition of midwifery published in the midwifery special issue of the *Lancet* journal in 2014. A midwife is defined as a professional who provides skilled, knowledgeable and compassionate care to women, babies and families before and during pregnancy, at birth and during the first weeks after birth.[21] Similarly, in 2012, the Great Britain's National Health Service (NHS) developed a new vision and new values and strategies in nursing and midwifery care practices and emphasized the use of the '6C' concept. This 6C concept says that care means care, compassion, competence, communication, courage and commitment.[11,22,23] The ethical codes and values of the midwifery direct them to work with compassion. Thus, the concept of 'compassionate midwifery' is inherent in this profession. Recently, researchers tried to understand what constitutes compassionate midwifery, which is considered as a relatively new concept in midwifery, to increase knowledge about

midwifery and to develop practice. However, this concept has not been sufficiently explored in the international literature and there are still a low number of definitions of compassionate midwifery. Studies on this subject have mainly focused on the definition of suffering, emotions, motivation and action, which are the elements of the process of compassion.[1,3,8] Compassionate midwifery is defined as the easement of pain through authentic presence, realization of suffering and pain, empathy, emotional commitment, motivation for support, strengthening the women, and knowledge and skills.[4] Pearson published an article in 2018 and indicated that empirical studies on this subject should examine compassionate midwifery. This would create a potential to take the process further and new findings will allow to develop the theory of compassionate midwifery. Pearson[24] also analysed the experiences regarding the development of the 'Compassionate and Professional Midwifery' module for the undergraduate curriculum of the University of Nottingham and emphasized that the literature provides insufficient support on how this concept should be taught in midwifery education.

Materials and methods

This descriptive study was carried out between 1 February and 15 April 2019 with midwives working in delivery rooms of hospitals affiliated to the Ministry of Health in Kocaeli. The study population consisted of 80 midwives who actively work in the delivery rooms of six different hospitals affiliated to the Ministry of Health in Kocaeli. No sample selection was made since the aim was to reach all midwives working in delivery rooms in Kocaeli regardless of the institutional difference. The study was carried out with 78 midwives since two midwives rejected to participate. The approval of the Ethics Committee of the Ministry of Health was obtained (approval No: 2019/17) prior to the start of the study. Data were collected with the 'Introductory Information Form' and the 'Compassion Scale'.

Introductory information form

This form was prepared by the researchers and consisted of 15 questions regarding socio-demographic characteristics such as age, education, and years of working and working conditions of the midwives.

Compassion scale

This scale was developed by Pommier.[25] Akdeniz and Deniz[26] adapted the scale to Turkish and carried out its validity and reliability study. The scale consisted of 24 questions scored using a 5-point Likert-type scale (never = 1, rarely = 2, sometimes = 3, often = 4, always = 5), under six subscales: 6, 8, 16, 24 (kindness); 2, 12, 14, 18 (indifference); 11, 15, 17, 20 (being aware of what is shared); 3, 5, 10, 22 (separation); 4, 9, 13, 21 (mindfulness); and 1, 7, 19, 23 (disengagement). The subscales of indifference, separation and disengagement are reversely scored. Then, the total mean score was taken. A higher total scale score shows a higher level of compassion. Akdeniz and Deniz[26] found the Cronbach's alpha value to be 0.85. The internal consistency reliability coefficients of the subscales were found to be 0.73 for kindness, 0.64 for indifference, 0.66 for being aware of what is shared, 0.67 for separation, 0.70 for mindfulness and 0.60 for disengagement. The results of the Pearson Product-Moments Correlation Analysis regarding test–retest reliability were $r = 0.75$ for the total score, $r = 0.66$ for kindness, $r = 0.60$ for indifference, $r = 0.60$ for being aware of what is shared, $r = 0.68$ for separation, $r = 0.68$ for mindfulness and $r = 0.71$ for disengagement.[26] In the present study, the Cronbach's Alpha value was found to be 0.80.

Data analysis

Data analysis was carried out using the appropriate statistical programmes. Frequency tables and descriptive statistics were used to interpret the results. Nonparametric methods were used for measurement values not suitable for normal distribution. In accordance with nonparametric methods, the 'Mann–Whitney U Test' (Z Table value) was used to compare the score of two independent groups, the 'Kruskal–Wallis H Test' was used to compare the scores of three or more independent groups and the Spearman correlation coefficient was used to examine the relationship between the scores.

Ethical Considerations

The study was approved by the Kocaeli Human Research Ethics Committee (approval date and number: 2019 / 17). Declaration of Helsinki was signed by all of the authors and presented to the ethics committee. Midwives were informed about the study, and voluntary participation was obtained. Data were collected through the use of an anonymous questionnaire, and the students were reminded that returning a completed study form implied informed consent. Permission has been obtained for using the Compassion Scale by Akdeniz and Deniz who adapted the scale to Turkish.

Results

The midwives' mean age in the study was 37.47 $\pm$ 9.53 (min = 23, max = 64). Of the participants, 75.6% were married, 41% had two children and 44.9% had undergone caesarean section. Of the participating midwives, 60.3% had a bachelor's degree. The participants' mean years of working was 16.02 $\pm$ 10.84 years (min = 1, max = 44). Of them, 67.9% worked in shifts, 66.7% worked in extra shifts (1 shift is defined as working for 16 h straight). The number of midwives decreases between 04:00 p.m. and 08:00 a.m., and only a single midwife works in some clinics.) Of the midwives, 32.1% cared for 6–10 pregnant women (in shift), 65.4% participated in 1–5 traumatic birth experiences (monthly) and 47.4 % stated that they were only partially satisfied with their job (Table 1).

The midwives' mean compassion score was found to be 4.19 $\pm$ 0.39; the median score being 4.25, the lowest score being 3.04 and the highest score being 5.0. The participants' mean scores on the subscales of the compassion scale were as follows: kindness 4.37 $\pm$ 0.53, indifference 1.78 $\pm$ 0.58, being aware of what is shared 3.94 $\pm$ 0.63, separation 1.83 $\pm$ 0.64, mindfulness 4.28 $\pm$ 0.58 and disengagement 1.81 $\pm$ 0.58 (Table 2).

The Kruskal–Wallis H test showed that the indifference subscore was lower in the age group of 31–40, compared to the others, which yields a statistically significant difference ($p < 0.05$) (Table 3). The Mann–Whitney U test showed no significant difference between the total scale score and subscore based on marital status. The 'children' and 'birth' statuses was also analysed using the Kruskal–Wallis H test and no significant differences were found ($p > 0.05$).

The total compassion score and subscores were compared based on the midwives Professional characteristics using the Kruskal–Wallis H test and Mann–Whitney U test (Table 4). The 'educational status', 'years of working' and 'total years at the institution' were grouped categorically. In Turkey, midwifery education has been provided at undergraduate level since 1997. Midwives who had graduated before this date (from high schools and upper secondary education programmes) had received different trainings. As per the law, all of these midwives are accepted as professionals. The Kruskal–Wallis H test showed no significant difference between the groups' total compassion scores and subscores based on the participants' educational status, years of working and total years of the institution ($p > 0.05$).

The groups' examination total compassion scores and kindness subscores showed a significant difference based on their work schedule ($p < 0.05$). The kindness subscore and total compassion score were

Table1. Distribution of characteristics of participants.

Variables (n = 78)		n	%
Age		37.47 ± 9.53	(23–64)
Marital status	Married	59	75.6
	Single	19	24.4
Children	No children	21	26.9
	1 child	22	28.2
	2 children	32	41.0
	3 children	3	3.8
Births	Nulliparous	21	26.9
	Normal birth	20	25.6
	Caesarean section	35	44.9
	Normal birth and caesarean section	2	2.6
Educational status	Vocational school of health	7	9.0
	Upper secondary education	16	20.5
	Bachelor's degree	47	60.3
	Master's degree	8	10.3
Years of working (16.02 ± 10.84) (min = 1, max = 44)	10 years and less	32	41.0
	11–20 years	17	21.8
	21 and above	29	37.2
Duration of working at the institution	Less than 1 year	13	16.7
	1–5 years	25	32.1
	6–10 years	23	29.5
	11 years and more	17	21.8
Work schedule	Only day shift	22	28.2
	Only night shift	3	3.8
	Shift work	53	67.9
Number of monthly extra shifts	No extra shifts	21	26.9
	1–5 extra shifts	4	5.1
	6–10 extra shifts	52	66.7
	11 and more extra shifts	1	1.3
Number of pregnant women in one shifts	1–5 pregnant	18	23.1
	6–10 pregnant	25	32.1
	11–20 pregnant	17	21.8
	21–40 pregnant	18	23.1
Monthly traumatic births	None	5	6.4
	1–5 traumatic births	51	65.4
	6–10 traumatic births	18	23.1
	11 traumatic births and more	4	5.1
Satisfaction with work	Satisfied	29	37.2
	Partially satisfied	37	47.4
	Not satisfied	12	15.4

significantly lower in midwives working shifts, compared to the others. The monthly number of shifts was grouped categorically and analysed using the Kruskal–Wallis H test. Only the subscore of being aware of what is shared showed significant differences between the groups based on the monthly number of shifts ($p < 0.05$). The groups were also categorized according to number of women cared for and analysed using the Kruskal–Wallis H test, which showed significant differences between the groups' total compassion scores and kindness subscores ($p < 0.05$). The midwives were also categorized according to the number of traumatic births and the total compassion score showed a significant difference between the groups in terms

Table 2. Descriptive data on the midwives' compassion scale and subscales.

Variables	Mean	SD	Median	Minimum	Maximum
Compassion scale	4.19	0.39	4.25	3.04	5.00
Kindness	4.37	0.53	4.50	2.50	5.00
Indifference[a]	1.78	0.58	1.75	1.00	3.25
Being aware of what is shared	3.94	0.63	4.00	2.00	5.00
Separation[a]	1.83	0.64	1.75	1.00	3.75
Mindfulness	4.28	0.58	4.25	2.25	5.00
Disengagement[a]	1.81	0.58	1.75	1.00	3.50

SD: standard deviation.
[a]Reverse scoring was taken for the calculation of the total compassion score.

Table 3. Comparison of the midwife's age with the compassion scale and subscales scores.

Variable (n = 78)	n	Mean rank (sum of rank)						
		Kindness	Indifference	Being aware of what is shared	Separation	Mindfulness	Disengagement	Total compassion score
Age								
30 and younger	27	35.78	34.17	42.13	**43.31**	36.02	37.48	39.22
31–40	25	43.34	40.94	40.32	**27.24**	45.04	36.96	45.08
41 and older	26	39.67	43.65	35.98	**47.33**	37.79	44.04	34.42
χ^2		1.498	2.518	1.051	**11.401**	2.339	1.603	2.831
p		0.473	0.284	0.591	**0.003**	0.311	0.449	0.243

Bold values: Results are significant if p = 0.05.
The nonparametric Kruskal–Wallis H test was used.

of the total compassion score ($p < 0.001$). The groups' kindness and indifference scores also showed a significant difference based on the number of traumatic births ($p < 0.05$).

The midwives' job satisfaction status was analysed using the Kruskal–Wallis H test and a significant difference was found between the groups' kindness subscores ($p < 0.001$). Particularly those who responded 'I am satisfied' had higher scores than those who responded 'I am partially satisfied' and 'I am not satisfied'. The participants' disengagement and separation subscores and total compassion scores also showed significant differences based on their satisfaction status ($p < 0.05$). The Mann–Whitney U test was used to assess whether the midwives chose their profession willingly or unwillingly, which yielded no significant difference between the groups' total compassion scores ($p > 0.05$), but yielded a significant difference between their subscores on being aware of what is shared.

The Spearman Correlation Analysis showed a positive relationship of the midwives' indifference subscore and the variable of age and years of working (Table 5).

Discussion

The ethical codes and values of the midwifery profession, which focus on women, direct midwives to provide a more compassionate care. Midwives, who witness the uniqueness of birth in the delivery room, are expected to be more sensitive in terms of compassionate care. The present study was carried out with

Table 4. Comparison of the professional characteristics of midwives and the scale of compassion and its subscales.

		Mean rank (sum of rank)						
Variable (n = 78)	n	Kindness	Indifference	Being aware of what is shared	Separation	Mindfulness	Disengagement	Total compassion score
Years of working								
10 years and less	32	36.27	34.39	41.03	41.58	37.77	38.20	39.59
11–20 years	17	44.82	37.50	35.97	30.97	47.41	35.74	45.76
21 years and more	29	39.95	46.31	39.88	42.21	36.78	43.14	35.72
χ^2		1.656	4.464	0.582	3.151	2.748	1.348	2.110
p		0.437	0.107	0.748	0.207	0.253	0.510	0.348
Work schedule								
Only day shift	22	**49.34**	37.02	38.45	34.75	45.18	33.34	**46.50**
Only night shift	3	**65.00**	29.17	54.33	24.00	52.17	51.17	**60.50**
Shift work	53	**33.97**	41.11	39.09	42.35	36.42	41.40	**35.41**
χ^2		**11.484**	1.178	1.385	3.270	3.382	2.849	**6.420**
p		**0.003**	0.555	0.500	0.195	0.184	0.241	**0.040**
Number of monthly extra shifts								
No extra shifts	21	49.60	35.86	**40.60**	32.74	48.00	31.21	48.81
1–5 extra shifts	4	40.25	28.25	**13.25**	37.88	46.88	24.75	41.25
6–10 extra shifts	52	35.29	41.63	**41.76**	41.77	35.12	43.97	35.99
11 and more extra shifts	1	43.50	50.50	**4.00**	70.00	59.50	40.00	19.50
χ^2		6.206	2.265	**8.612**	4.305	6.261	6.661	5.606
p		0.102	0.519	**0.035**	0.230	0.100	0.084	0.132
Number of pregnant women in one shifts								
1–5 pregnant	18	**54.86**	35.11	41.56	35.42	50.19	37.00	**50.31**
6–10 pregnant	25	**32.58**	41.24	38.60	45.12	35.04	42.02	**34.14**
11–20 pregnant	17	**29.29**	48.32	40.85	41.56	34.32	40.79	**30.94**
21–40 pregnant	18	**43.39**	33.14	37.42	33.83	39.89	37.28	**44.22**
χ^2		**15.082**	4.912	0.411	3.454	6.021	0.772	**8.717**
p		**0.002**	0.178	0.938	0.327	0.111	0.856	**0.033**
Monthly traumatic births								
None	5	**48.70**	**22.00**	54.50	24.00	61.30	32.20	**63.10**
1–5 traumatic births	51	**44.90**	**36.75**	37.39	37.78	40.70	37.55	**42.29**
6–10 traumatic births	18	**22.19**	**52.08**	36.56	49.36	30.72	48.06	**23.28**
11 traumatic and more	4	**37.00**	**39.75**	60.88	36.38	36.50	35.00	**47.38**
χ^2		**14.759**	**9.461**	6.669	6.235	7.735	3.694	**15.940**
p		**0.002**	**0.024**	0.083	0.101	0.052	0.296	**0.001**
Work satisfaction status								
Satisfied	29	**51.09**	32.12	38.72	**32.86**	45.41	**32.09**	**49.57**
Partially satisfied	37	**31.18**	43.66	39.84	**46.76**	36.08	**46.36**	**32.11**
Not satisfied	12	**37.17**	44.50	40.33	**33.17**	35.75	**36.25**	**37.96**
χ^5		**13.138**	5.003	0.060	**7.360**	3.227	**6.884**	**9.739**
p		**0.001**	0.082	0.970	**0.025**	0.199	**0.032**	**0.008**

Bold values: Results are significant if p = 0.05 and p = 0.001.
The nonparametric Kruskal–Wallis H test and Mann–Whitney U test were used.

Table 5. Spearman correlation analysis results determining the differences between the ages of the midwives, years of working, compassionate scale total scores and subscores.

		Age		Years of working	
Variable	n	r	p	r	p
Total compassion score	78	–0.084	0.467	–0.072	0.534
Kindness	78	0.062	0.589	0.076	0.510
Indifference	**78**	**0.240**	**0.034**	**0.260**	**0.022**
Being aware of what is shared	78	–0.045	0.697	0.020	0.859
Separation	78	0.060	0.601	0.031	0.788
Mindfulness	78	–0.024	0.834	–0.019	0.867
Disengagement	78	0.101	0.377	0.088	0.442

Bold values: Results are significant if $p = 0.05$.
The Spearman Correlation Analysis was used.

midwives working in the delivery room, and found a total mean compassionate score of 4.19 ± 0.39. Considering that the highest score is 5, it can be concluded that the midwives had high compassionate levels, which indicates that they exhibit a compassionate attitude. This finding is similar to the total compassionate scores obtained in studies carried out in Turkey with nurses and physicians.[27,28] Respect for an individual and communication within the framework of human dignity and the fundamental values of compassion increase patient satisfaction and care quality.[11] Therefore, these results can be evaluated as satisfactory. Among the demographic characteristics, only age was found to affect the midwives' total compassion scores. But the total compassion score was also affected by professional factors such as the number of women cared for, shift work, the number of traumatic births and work satisfaction. In addition, some subscores such as kindness, indifference and being aware of what is being shared were also found to be affected by some of the professional characteristics of the midwives. Kindness subscore decreased as a number of shift work, women cared for and traumatic births increased. A study conducted on individual and relationship factors that affect the compassionate care practice of health professionals in North-western England found that leaders acting as positive role models, good relationships between team members and a focus on the welfare of staff were effective in providing compassionate care.[29] According to a study carried out in the Northwest of Iran, insufficient staffing and extreme workload negatively affected compassionate care. To address this problem, the policy makers, managers and healthcare providers should create an organizational atmosphere suitable for compassionate care.[30] In England, it was reported that midwives continue to provide compassionate care and try to do their best even under the most difficult conditions such as struggling with management structures and increased workload. It was emphasized that despite all the difficulties, midwives should be able to stay with the pregnant woman at all stages of the birth process, to try to understand her, to support her and to create opportunities to provide compassionate care.[31] According to a study on the burnout levels of midwives in Turkey, midwives with longer working experience had higher emotional burnout and depersonalization levels.[32] In the present study, the kindness subscore of midwives who were satisfied with their job were higher than those who were not satisfied. In addition, those who were satisfied with their job had lower indifference and separation subscores. Job satisfaction positively contributes to service quality. Midwives' high job satisfaction ensures a more caring and compassionate approach towards women.[33] The present study found that midwives' in difference score increased as their age, years of working as midwives and the number of traumatic births increased. Longer years of working could make the midwives more indifferent. This higher indifference level of more experienced midwives, when their knowledge and skills are most developed, can be evaluated as compassion fatigue. According to Crawford et al.,[34] health professionals are expected to always be compassionate, which they consider to be

an important goal, but health professionals stated that the absolute 'consistent compassion' expected from them is not realistic.[34] Compassion fatigue, which was first identified in nurses in the 1950s, can explain this situation. Compassion fatigue is defined as a state characterized by gradual decrease in compassion over time.[35] Studies on this issue, particularly in the field of nursing, indicated that healthcare personnel who experience traumatic events are at risk for compassion fatigue.[35–37] Compassion fatigue, defined as a debilitating fatigue that occurs due to empathic reactions to painful and recurrent suffering, can professionally and personally affect all healthcare personnel, including midwives.

Studies have shown that midwives wanted to leave their profession due to extreme work load and secondary trauma experiences.[1] Therefore, the risk factors and protective behaviours against compassion fatigue should be determined. The researchers emphasized the importance of encouraging a positive working culture, supporting colleagues and other health professionals, and leading midwives. Health policy makers also sensitively approach this issue.[23,3–2]

Hall[23] requested midwives to ask themselves, 'What should we do as midwives if the values we hold are not there anymore?'

Conclusions and recommendations

Midwives should be committed to the value of compassion, in accord with professional ethics, and show a compassionate attitude. But various factors regarding the work environment negatively affect the conditions of compassion. The number of women cared for, the number of traumatic births and those satisfied with their job reduce midwives' kindness and compassion levels. Longer years of working make them more indifferent. However, it should be noted that every woman has the right to receive honourable and compassionate care.

Midwives should believe and uphold, with national and international campaigns, that every woman/person has the right to receive honourable and compassionate care and that this is a basic fundamental human right. The risk factors for compassion fatigue should be identified for midwives who fulfil their responsibilities. In addition, emphasis should be put on facilitation of positive working cultures and the support of colleagues and another health professional. In addition, leading midwives and health policy makers should be sensitive to this issue. The number of pregnant women per midwife should be decreased to facilitate women's/families' access to compassionate care and the word 'compassion' should be included into health strategy, policy, hiring and training processes. Further qualitative studies should be conducted to examine the levels of compassion to culturally competent midwifery care, based on compassion, as well as studies to be conducted in other countries.

Limitations of the study

The strength of this study is that it is the first study that examines the compassion levels of midwives in Kocaeli, in western Turkey. However, this study has two important limitations. First, no observations have been performed regarding the levels of compassion. Second, the literature can be enriched with studies on midwives' compassion fatigue along with their compassion levels.

Acknowledgements

We sincerely thank all of the midwives who participated in this study.

Authors' contributions

A.E. and M.O. designed the study, conducted literature searches and provided summaries of previous research studies. S.D.A. conducted the statistical analysis. A.E., M.O. and S.D.A. wrote the first draft of the manuscript and all authors contributed to and have approved the final manuscript.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

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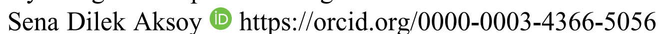
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