personal skills in order to gain patients' trust and motivate them.

Conclusion This study elucidates the barriers and enablers to social prescribing for patients with mental health problems, from the perspectives of GPs. Recommended interventions include a more systematic feedback structure for GPs and more formal training around social prescribing and developing the relevant inter-personal skills. This study provides insight for GPs, commissioners and community groups, to help design and deliver future social prescribing services.

4 'BLEEDING ANTIBIOTICS': NEGOTIATING CARE AND TRUST IN TURKISH HEALTHCARE INFRASTRUCTURES

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Antibiotic prescriptions make up a quarter of all prescriptions in Turkey. These locally 'ordinary' pharmaceutical commodities are used as tokens of care, enablers of treatment and legitimisers of illness to navigate in everyday healthcare infrastructures. Patients express embodied experiences of antibiotics circulating in their blood stream to reveal the abundance of antibiotic use in their medical histories. Yet access to antibiotics is becoming increasingly regulated, which is necessitating negotiations of care and trust amongst patient, doctors and pharmacists. Antibiotics, which for a long time have been reliable and easily accessible objects of care, are now proving less effective as treatment. With the growing concern of antimicrobial resistance (AMR), the over-the-counter sales of antibiotics have stopped in Turkey since 2015. Which means that antibiotics are only legally available through a doctor's prescription. Moreover, the COVID-19 pandemic has recently limited doctor consultations, further restricting access to prescription medication.

This paper explores the implications of the recent regulations and AMR on prescription practices, patient experiences and patient-doctor relationships within antibiotic infrastructures. The research draws on a three-month ethnographic fieldwork in Istanbul, Turkey, to understand negotiations of care and trust in processes of prescribing and acquiring antibiotics during the COVID-19 pandemic. The theoretical framework of the research is rooted in medical anthropology. Drawing on qualitative interviews with doctors, pharmacists and patients, as well as participant observation in an unfolding pandemic, this study shows that antibiotic prescription processes are becoming embedded in negotiations between patients, doctors and pharmacists. Moreover, despair amidst tension and uncertainty is increasing the contingency of navigating care and trust in the healthcare system to enable alternative ways of access to antibiotics.

5 INDIAN MIDDLE-CLASS WOMEN AND POSTPARTUM DEPRESSION: UNDERSTANDING THE INFLUENCE OF TRADITIONAL GENDERED SOCIALIZATION

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Background Globally the prevalence of postpartum depression amongst women ranges from 10%-15% per 1000 births.

However, many middle-class Indian women are dismissive about postpartum depression, often seeing it as a 'Western' mental disorder and considering it as 'medicalization' of the post-birth experience.

Objective Exploration of culturally specific expectations posed on Indian middle-class women in terms of what is mentally and physically permissible and non-permissible in 'motherhood' – how traditional gendered socialization influences women's medical beliefs and results in their dismissive attitude towards postpartum depression.

Method The researcher has conducted ethnography of seven middle-aged mothers based in Kolkata and their natal, conjugal and extended family members, to understand the expectations about biological 'motherhood' posed on women before and during their childbearing ages, women's post-birth experiences and women's sense of social and personal fulfilment in motherhood.

Results Culturally women suffering from postpartum depression are denied a 'sick role' as suffering is often understood as a 'social experience' and not only as an individual physical or mental one. Hence not denying the existence or not disowning their own experiences of postpartum depression poses new mothers a risk of being 'stigmatized' as it threatens to taint the image of 'motherhood' as constructed by Indian society. The non-perception of 'postpartum depression' as a mental disorder needing medical intervention often stems from the 'trust' women seem to have on their gendered socialization which imbibes them with the idea that birth of one's child is a joyful celebratory event – highest state of femininity, thereby shifting the focus from the mother to the newborn.

Conclusion When women have high traditional gender role conformity it causes women's social identity to overwhelm their personal identity - causing an 'alienation' from their own mental and physical needs in an effort to perform the socially mandated 'ideal type' of acceptable womanhood.

6 PARTNERING WITH CHILDREN IN HEALTHCARE: NO PARTNERSHIP WITHOUT TRUST

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Background The concept of patient-partnership in health services planning has become best practice in healthcare in numerous countries. This partnership is central to improve healthcare outcomes for patients and normalize their role as active participants in improving services. However, children are rarely involved in decision-making processes in healthcare. We put forth a needed shift from children as passive subjects of healthcare delivery, to active agents who should engage in health services planning of relevance to them, as well as healthcare decision-making. By recognizing children as active agents, we can apply advances from the field of patient engagement to child health to offer more inclusive care.

Aim We will present the results of a scoping review on how to engage children as patient-partners.

Methods We used the Joanna Briggs Institute framework to guide the review and included articles on models or frameworks to engage children aged below 14 years old as patient-partners in health services planning and delivery. 90 articles were included in the analysis.

Results Four models to engage children as patient-partners have been identified: (1) Moving from family-centred care to child-centred care; (2) Using a triadic approach involving the healthcare professional, parent and child; (3) Using family-centred care while acknowledging the vulnerability of the child; (4) Involving the child patient on a level of participation based on cognitive development and competency. Throughout the analysis process, we identified ethical challenges that can occur when using the different models. Establishing trust with children and addressing issues related to power are the two most prevalent ethical challenges reported.

Conclusions The presentation will focus on these two key ethical challenges and highlight the different perspectives (i.e. from children, parents and healthcare providers) present in the qualitative literature on how to build trust with children in health services planning and delivery.

7 WOMEN'S ACCOUNTS OF ALTERED FETAL MOVEMENT: UNRELIABLE AND PRIVILEGED

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10.1136/bmjopen-2021-QHRN.7

Background Sociological literature has reported widely on the subjugation of pregnant women's embodied knowledge to obstetric technologies. Women's accounts of altered fetal movement have sometimes been dismissed, with poorly-managed episodes of reduced fetal movement highlighted as an important contributory factor to avoidable stillbirth. NHS England's 2016 Saving Babies' Lives care bundle included recommendations for the management of reduced fetal movement as part of a national strategy to reduce stillbirth.

Aim To explore how different forms of knowledge about fetal movement are evaluated and prioritised before, during and after the clinical encounter.

Methods This research used an ethnographic approach to compare practice relating to fetal movement at two UK maternity units, with over 200 hours of observation, interviews, and document analysis. Field notes, interview transcripts, policy documents, maternity notes and clinical guidelines were analysed to identify key themes.

Results Despite no cases of women's accounts being dismissed, many clinicians presented altered fetal movement as a highly subjective and unreliable symptom. Women's reports of a quiet baby were not always consistent with clinicians' own impressions of fetal movement, or with the evidence generated by 'objective' monitoring devices. Nonetheless, in accordance with clinical guidance, if a woman reported altered fetal movement at or beyond 39 weeks' gestation, the decision to expedite the birth through induction of labour was regularly made based on her account alone.

Conclusions In the risk-averse maternity setting, and amid a national campaign to reduce stillbirth, clinicians are under considerable pressure to act promptly on women's reports of altered fetal movement, whether or not they trust them. This imperative to act without clear evidence of fetal compromise can be interpreted as a disruption to the established knowledge system, with women's embodied knowledge apparently being privileged – in this scenario at least – over the evidence generated by high-status obstetric technologies.

8 'DEALING WITH THE BABY YOU LOST AND THE LOSS OF THE FUTURE': CHI – A RECURRENT PLACENTAL CONDITION

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10.1136/bmjopen-2021-QHRN.8

Background Chronic histiocytic intervillitis (CHI) is a rare, poorly-understood placental condition causing pregnancy loss. Unlike many other causes of stillbirth, CHI has a recurrence rate of 50–80% in future pregnancies and has limited treatment options.

Objectives To understand the impact of CHI on women who have experienced pregnancy loss and to ascertain their healthcare needs.

Methods We conducted a focus group discussion (FGD) with three women affected by CHI, recruited through a Facebook support group. The FGD was facilitated by the lead author and a peer-researcher. It was transcribed verbatim and analysed thematically. It is part of a larger clinical study (MIR-APO) which was approved by the London Research Ethics Committee (19/LO/0105).

Results Lack of knowledge about CHI amongst healthcare providers (HCP) often resulted in inadequate or inaccurate explanation of the condition; limited advice on future treatment options; and lack of patient information. This led women to lose trust in HCPs, feeling that they had to seek and arrange their own care, often drawing upon a network of other women with CHI.

The recurrent nature of CHI is particularly challenging, causing women to lose trust in their ability to carry a baby. They described a 'double grief': firstly, for their loss of their baby; secondly, for the loss of the future they had envisaged. The high likelihood of recurrence provoked anxieties about future pregnancies, including unproven treatment regimens and the possibility of further loss. Participants identified continuity of care from HCPs (e.g. bereavement midwives, or an obstetrician familiar with CHI) as an important source of hope and support.

Conclusions Lack of awareness around CHI leads to inaccurate information, misplaced reassurance, and failure to refer for appropriate management. This erodes trust and has significant psychological sequelae. In response to these findings, we are developing resources on CHI for patients and providers.

9 COMMUNICATION OF UNCERTAINTY, DIAGNOSIS AND TRUST

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Background Diagnosis is a complex and challenging clinical and communicative task. The rate of diagnostic errors, including missed, delayed, and misdiagnosis, has remained prevalent at 10–15% over the last few decades (Graber, 2013). Diagnostic errors can be a major cause of loss of trust in the doctor-patient relationship. Clinicians use 'diagnostic statements' to name, describe or explain the health problem to patients. If uncertain, clinicians are encouraged to share their working diagnosis and give an indication to their level of uncertainty.