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**VALUES BASED RECRUITMENT IN MIDWIFERY: DO THE VALUES ALIGN
WITH WHAT WOMEN SAY IS IMPORTANT TO THEM?**

Abstract

Aim: To discuss theoretical conceptualisation and definition of values and values-based recruitment in the context of women's views about what they would like from their midwife.

Background: Values-based recruitment received headline status in the UK government's response to pervasive deficiencies in compassionate care identified in the health service. Core values which aim to inform service user's experience are defined in the National Health Service Constitution but clarity about whether these encompass all that women say is important to them is needed.

Design: Discussion paper

Data Sources: A literature search included published papers written in English relating to values, VBR and women's views of a 'good' midwife with no date limiters.

Discussion: Definitions of values and values-based recruitment are examined. Congruence is explored between what women say is important to them and key government and professional regulatory documentation. The importance of a 'sustainable emotional' dimension in the midwife-mother relationship is suggested.

Conclusion: Inconsistencies are identified between women's views, government, professional documentation and what women say they want. An omission of any reference to emotions or emotionality in values-based recruitment policy, professional recruitment and selection guidance documentation is identified.

Implications: A review of key professional documentation, in relation to selection for 'values', is proposed. We argue for clarity and revision so that values embedded in values-based recruitment are consistent with health service users' views. An enhancement of the

'values' in the values-based recruitment framework is recommended to include the emotionality that women state is a fundamental part of their relationship with their midwife.

Key words: midwifery, nursing, values, values-based recruitment, emotions, emotional intelligence, care

Summary Statement

Why is this research or review needed?

- The current drive for selecting health care student and UK National Health Service (NHS) staff according to their values is a key deliverable from the government to Health Education England (HEE).
- There appears to be a lack of congruence between the NHS Constitution values and what women say they want from maternity service care providers

What are the key findings?

- Women value technical and practical skills as well as their relationship with their midwife
- The midwife-mother relationship features an emotional dimension which is hard to define and therefore difficult to incorporate into a recruitment framework
- This ‘sustainable emotionality’ is missing from key regulatory documentation and the NHS Constitution values

How should the findings be used to influence policy, practice, research and education?

- Key regulatory, professional and government documentation should review their values framework and consider incorporating an emotional dimension which appears to be important to women accessing health care services
- Values congruence should be a feature between professional, regulatory documentation and the Department of Health/HEE

INTRODUCTION

The Francis Report (2013) focused national attention on the standards of care being provided to people in the England accessing health care services. The Berwick Report, (2013) emphasised the importance of placing quality of patient care above all other aims and in the same year the Cavendish Report (2013) recommended that the process of health professional recruitment should include values assessment to ensure that those employed provide compassionate care to service users. The United Kingdom (UK) National Health Service (NHS) Constitution identified the values considered to be integral to a health service where ‘care and compassion matter the most’ (DH 2012). Values-based recruitment (VBR) has emerged as a vehicle for implementing these recommendations. As a result individuals are purposively recruited and selected for health care professions on the basis that their personal values align with the values written in NHS Constitution (DH, 2013): ‘respect and dignity’; ‘commitment to quality of care’; ‘compassion’; ‘working together for patients’; ‘improving lives’ and ‘everyone counts’.

In this paper VBR is discussed specifically in relation to midwifery care provision. ‘Values’ are defined followed by consideration of whether the NHS Constitution values are fit for purpose in relation to VBR. The discussion then focuses on what is important to women in the caring relationship with their midwife with particular focus on an emotions dimension. Values congruence is examined between government, professional regulatory documentation and women’s views. New perspectives are generated which aim to inform future considerations of how the maternity workforce is selected. The generic relevance of this work to the selection of health care staff and students, nationally and internationally is suggested. Every country in the world offers care services to child-bearing women and the personal attributes of those providing these services currently feature in global considerations of what

is important in the post-millennium development goal agenda (World health Organisation, WHO, 2012).

The aim of this paper is to discuss theoretical conceptualisations of values and values based recruitment. Critical appraisal of specific approaches to undertaking VBR including, for example, multiple mini interviews (MMIs) can be found in complementary publications by the authors (Callwood *et al.*, 2012, Callwood *et al.*, 2014, Callwood, 2015).

Data Sources: The following databases were searched: British Education Index, CINAHL, Education Administration Abstracts, ERIC, MEDLINE, PsycARTICLES, Psychology and Behavioural Sciences, PsycINFO, ASSIA, British Nursing Index and Sociological Abstracts in addition to the Nursing and Midwifery Council (NMC) and International Confederation of Midwives (ICM) websites.

Search terms included: values, 'values-based recruitment', 'good character', selection, midwi* OR 'student midwi*', mother, 'good midwi*' with relevant string combinations. No date limiters were applied. This approach was designed to capture both seminal theoretical conceptualisations of 'values' as well as more recent publications about valued-based recruitment.

BACKGROUND

Conceptualising and Defining Values in the Healthcare Context

Values are cognitive representations of enduring goals, reflecting personal choice to act in a certain way (Roccas *et al.* 2002). They impact on behaviour and are influenced by motivation (Parks & Guay 2009). Values hold different degrees of importance from individual to individual. A particular value may be important to one person but unimportant to another

(Schwartz 2012). As learned beliefs, values can change or adapt over time (Parks & Guay 2009).

The use of the word 'values' and its explicit and implicit meanings are inconsistent. Patterson *et al.* (2014) suggest values research ascribes to one of two models: either values as 'preferences' (or work values) which are attitudes displayed by individuals indicating their preference for different environments or values as 'principles' guiding how individuals feel they ought to behave (Ravlin & Meglino 1987). They suggest that both are relevant to VBR where worked-based judgements are as important as personal principles.

In 1992 Schwartz published his taxonomy of values which features 10 domains which are reportedly recognised across cultures (Box 1). Extensive international studies (Schwartz 1992, 1994, 2006, Jowell *et al.* 2007) have led to the widespread validation of this values theory.

Schwartz (1992) also describes values as: 'evaluative' meaning they guide personal judgements in relation to appropriate behaviours; 'general' as they can transcend different situations and 'ordered by importance' where an individual will act according to the more important value when multiple values are in conflict for example, individuals may act less benevolently if their achievement values are threatened. The significance of the differing values appears to be context specific. This is illustrated by the NHS Constitution values and the 'British values' (democracy, rule of law, individual liberty, mutual respect for and tolerance of those with different faiths, beliefs and for those without faith) espoused by Ofsted (Department of Education, 2014). These two prominent UK institutions both align their service with important values but they are different. The complexity of defining values

is acknowledged particularly when constructing a national framework on which values are the fundamental principles.

Reaching a consensus about the values important in health care provision is exemplified in the inconsistencies apparent in midwifery and nursing regulatory documentation. In the Nursing and Midwifery Council (NMC) admission criteria it states that all applicants must demonstrate that they have 'good character sufficient for safe and effective practice' (NMC 2009, p.10). According to the NMC (2010) 'good character' is based on an individual's conduct, behaviour and attitude taking into consideration any convictions, cautions or pending charges. The only key values featured are: being accountable, fair, professional, progressive and inclusive. No further explanation of how the NMC defines values is evident.

The NMC Standards for Pre-Registration Midwifery Education (2009) allude to 'personal attributes', not values, in their framework of competencies which students are required to achieve for entry in the professional register. 'Competent' is defined as the 'combination of skills, knowledge, attitudes, values and technical abilities that underpin safe effective practice' (NMC, 2010, p. 11). Competencies are divided into four domains: 'effective midwifery practice'; 'professional and ethical practice'; 'developing the individual midwife and others' and 'achieving quality of care through evaluation and research'. At the core of these competencies are personal skills including 'effective communication', 'empathy', 'respect' and 'sensitivity'; however, a definitive list of values is not present.

The International Confederation of Midwives (ICM) also refer to 'competencies' rather than specific values in their key documentation (ICM 2011) Competencies are described as 'the knowledge, skills and behaviours required of the midwife for safe practice in any setting' (ICM 2011, p. 1). They are summed up in specific 'key midwifery concepts' which further define the unique role of the midwife including: working in partnership, respect for human

dignity, advocacy and cultural sensitivity (ICM 2011). The ICM refer to ‘values’ in just one section titled ‘basic professional behaviours’ where it states that the midwife should ‘act consistently in accordance with professional ethics, values and human rights’ (ICM 2011, p. 4). No further clarification is offered. More recently, the ICM International Code of Ethics (2014) implicitly refer to values but they are not explicitly defined.

Our understanding of the literature cited here is that there are inconsistencies in how ‘values’ are conceptualised and defined between the NMC, ICM and the NHS Constitution documentation. This adds complexity to Higher Education Institutions (HEIs) selection processes regarding how to assess ‘values’ and whom to accept onto education programmes. Noteworthy is that the NMC and the ICM do not specifically mention VBR in their admissions guidance. To add to the challenge of this decision-making, the Government’s mandate (DH, 2013) to HEE states that recruitment into all education and training programmes, including midwifery, should incorporate selecting for ‘values’ by 31 March, 2015. The Government clearly emphasise the core personal ‘values’ embedded in the NHS Constitution (DH 2012) but it is unclear whether these values reflect all that women state is important to them. Therefore women’s views are examined in the following discussion.

DISCUSSION

The Midwife-Mother Relationship

Each contact that a midwife has with a woman is a unique encounter. Midwives are with women at arguably some of the most vulnerable times in their lives (Raynor & England 2010). The significance that women place on their relationship with their midwife cannot be understated. Women reportedly rate a midwives’ ‘presence’ more highly than her ‘actions’ (Pembroke *et al.* 2008); the ‘being there’ is more important than what is said and done (Dahlen *et al.* 2010, Sjoblom *et al.* 2014). Others have demonstrated that women appreciate

midwives who are honest, respectful, prepared to listen, who are sensitive to their needs, who treat them as individuals (Green, 1990 *et al.* Walsh, 1999, Fraser, 1999, Fenwick, 2005) and who possess good communication skills (Nicholls *et al.* 2011). The absence of these features renders the woman insecure, lacking in trust and less satisfied with her birth experience (Berg *et al.* 1996, Beake *et al.* 2010). Women suggest that they value a midwife who is able to engage with them at different levels offering ‘caring encounters’ rather than ‘being absently present’ (Kirkham 2010, p. 38). The importance of an emotional dimension to care provision was highlighted by Tumblin & Simkin (2001) in their qualitative study exploring the expectations of a sample of primigravida women during labour. Fifty-seven women were asked what they expected from their care during labour and birth. One hundred and seventy four items were listed with 29% of the priorities related to emotional and informational support. Endorsing this, Beake *et al.* (2010) concluded that staff interaction had a direct impact on how women perceived their care. The most recent national Surveys of Women’s experiences of Maternity Care conducted in England (Care Quality Commission, 2013) and Scotland (The Scottish Government, 2014) also revealed that women rate ‘good communication’ highly at all stages of their care.

Kirkham (2009) suggests that the relationship between mother and midwife is founded on principles of respect, trust, reciprocity and emotional integrity. Without these a midwife will risk ‘doing to’ and ‘checking women’ rather than truly listening and being ‘with them’. Evidence suggests that women value the relationship with their midwife itself which is intrinsic to an expression of advice and support (Wilkins, 2010); not someone who is a ‘caring robot’ (Hunter & Deery, 2009). Emotional engagement and emotional sensitivity are central to meeting women’s needs but, in addition, midwives’ self-awareness and the ability to recognise and regulate their responses are essential to avoid burn out (Hochschild 1983, Deery 2007).

Emotions and Emotionality in Caring Relationships

The following critical appraisal of the literature is designed to explore the nuances of the relationship between mother and midwife from an 'emotions' perspective where current considerations are positioned in established theory. The relevance and implications for VBR are then discussed. Noteworthy is the recognition of the origins of this seminal writing in nursing care and its generic relevance to all health care providers.

Psychodynamic Theory

Peplau's (1952) first considerations of the dynamic nature of the nurse-patient relationship and how it changes over time and with experience is widely referred to as psychodynamic theory. Reflecting Gadamer's 'horizons of understanding' (1989) the fluidity of knowledge acquisition and experiential learning is assumed. The aim of psychodynamic care is for the nurse to understand their own behaviour, to help others identify felt difficulties and to apply principles of human relations to problem solving (Peplau 1989). Peplau explains that nursing is 'interpersonal' as it involves the interaction between two or more individuals who strive for a common good i.e. the shared experience between a nurse and her patient as opposed to the patient passively receiving treatment. Kirkham (2010) brings a contemporary midwifery - specific perspective, stating that the midwife-mother relationship is the foundation of maternity services. For many women that relationship is the service and from it can spring self-care and confidence. Peplau (1989) also refers to 'professional closeness' which requires the nurse to focus exclusively on the needs of the patient; the nurse should be aware of her own needs but her focus is to act to foster a therapeutic change in the patient. This 'therapeutic use of the self' where the nurse consciously makes use of her own personality and knowledge to effect change in the patient (Freshwater, 2002) underpins psychodynamic care philosophy. It remains an important approach to care provision in contemporary

healthcare services. Of specific relevance to this discussion are the emotions, 'emotionality' or the emotional implications of engaging in and sustaining such relationships and the associated personal qualities relevant to VBR.

Emotional Labour and Emotion Work

'Emotional labour' was first conceptualised by Hochschild (1983) as she observed flight attendants being told to 'smile like you really mean it' (Hochschild 2012, p. ix). The potential conflict between their outer portrayal of feeling and their inner feelings of possible anxiety, fear or resentment requires 'the induction or suppression of feeling to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place' (Hochschild 1983, p.7). The term 'emotional labour' distinguishes between the emotional and the physical labour that occurs in the work place. Smith (2012) further clarifies the construct, stating that emotional labour requires an individualised, trained response that assists in the management of patient's emotions in healthcare settings. She goes on to say that emotional labour 'intervenes to shape our actions when there is a gap between what we actually feel and what we think we should feel' (Smith 2012, p.12). In a nursing context, McQueen (2004) suggests that when nurses do not feel as they think they ought to feel in a specific situation, they engage in emotional labour to control and manage their response in a way that they perceive to be acceptable for a given situation.

Hochschild (1983) distinguished between 'emotional labour' and 'emotion work' suggesting that: 'emotional labour' is paid work performed in the public domain and is regulated by workplace rules, management and monetary remuneration ('sold for a wage', Hochschild, 2012, pp. 7); 'emotion work' takes place privately at home. More recently, Hunter & Deery (2009) allude to the personal and individuality of 'emotional labour' and 'emotion work' suggesting that they might be experienced differently by different people and also depend on

professional grouping. In midwifery, Hunter (2009) uses the term 'emotion work' to encompass both Hochschild's 'emotional labour' and 'emotion work'. This is in acknowledgement of the work midwives undertake in people's homes as well as in public institutions. These conceptual complexities challenge Hochschild's (1983) original definition and result in a lack of consensus about what 'emotional labour' is.

Theories of 'emotional labour' in relation to the emotion work required to display appropriate responses at work are particularly important in midwifery. The birth of a child is a life-changing event; it can be a time of unimaginable happiness or unimaginable loss. Women report valuing a 'connectivity' with their midwife (Olafsdottir 2009); midwives expertise involves a 'cluefulness' (Leap 2010) to respond to women's overt and covert needs appropriately. Theories of 'emotional labour' have thus been broadened to include the 'use of the self' in a therapeutic relationship (Peplau 1989, Freshwater 2002), meaning the 'caring work' that elicits emotion in addition to the effort needed to manage emotion (Hunter & Deery 2009). Hunter & Deery (2009) also suggest that a mother depends on her midwife being emotionally attuned to her needs. This is supported by Theodosius's (2006) work in nursing care where she proposes that emotional relationships connect individuals to each other; that most human relating is superficial and that when it does take place at any great depth, individuals attach great value and significance to it.

Theorists have been engaged in attempting to identify and define the essence of the therapeutic relationship between midwives and women (and patients and nurses) for decades. These considerations have important implications in relation to VBR. It is vital to unpick what 'it' is that women and midwives value in their relationship so that the personal qualities associated with potential to meet these demands can be identified in applicants to training and NHS posts through VBR. It is clear that working with emotions in a caring relationships is not easily achieved (Allan 2009); emotions are complex and terminologies classifying

emotional labour and emotion work are blurred. In this semantic confusion another phrase ‘emotional intelligence’ (EI) is featured in the literature. Like ‘emotional labour’, there are several definitions of EI resulting in a lack of theoretical congruity. It is pertinent to this discussion as aspects of EI theory encapsulate the personal qualities which might be considered to be important for an individual to be able to offer a sustainable emotional dimension to caring relationships.

Emotional Intelligence

The term ‘emotional intelligence’ was first documented in the 1920s by Edward Thorndike. Thorndike commented that an over-emphasis on academic intelligence using intelligence quotient (IQ) tests potentially under-valued ‘social intelligence’. Gardner (1993) explained ‘social intelligence’ as two types of personal intelligence: interpersonal and intra personal. Intrapersonal intelligence is the ability to form an accurate picture of oneself and to use this to function successfully in life. This is important in clinical practice where carers who are self-reflective and aware of their own values and prejudices can empathise and try to understand patients’ perspectives. Interpersonal intelligence is the ability to understand other people and to work co-operatively with them. In the working environment, Goleman (1996) suggests that those with good interpersonal intelligence can form relationships easily, read other people’s feelings and responses accurately, lead and organise. Intrapersonal intelligence is the ability to be self-aware, to recognise feelings in the self and how these impact on social behaviour. In clinical practice this is important to be able to empathise with patients, try to understand their position and engage in therapeutic relationships (McQueen 2004). Freshman and Rubino (2002, p. 1) used this conceptualisation of ‘social intelligence’, including interpersonal and intrapersonal skills, to define EI as: ‘a proficiency in interpersonal and intrapersonal skills in the areas of self-awareness, self-regulation, self-motivation, social awareness and social skills’. Importantly, McQueen (2004) links EI with

emotional labour stating that, while they are different concepts, emotional labour uses interpersonal and intrapersonal intelligences.

Emotional intelligence has been described in three different ways: as an 'ability' (Salovey & Mayer 1990), as a 'trait' (Bar-On, 1997, Petrides *et al.* 2010) or in mixed model combining both ability and trait (Goleman 1996). The 'ability' model (Salovey & Mayer, 1990) suggests individuals are able to monitor their own personal feelings and emotions, as well as those of others; and they are able to discriminate between them and use the knowledge gained to guide their own thinking and actions or emotional growth. As a fluid and interpretative construct, this model suggests that emotional intelligence can be developed.

The 'trait' model proposes that emotional intelligence is an enduring quality or behavioural disposition that, if present, will always exist (Bar On 1997, Petrides 2010). Individuals are born with characteristics that remain fairly constant throughout their lives. They react in a specific way across various situations rather than being flexible according to a specific situation.

Goleman's 'mixed' model (1996) rejects the conceptualisation of EI as either an 'ability' or a 'trait' in favour of a combination of both. He conceptualises EI as an array of skills and characteristics that drives performance. Goleman (1996) claims that emotionally intelligent people know their emotions, motivate themselves, recognise the emotions of others and handle emotions effectively. An emotionally intelligent individual may exhibit positive thinking, excellent communication skills, knowledge and performance, confidence, ability to put others at ease, emotional maturity, an ability to be at ease with the emotions of others, motivation, energy and focus, calmness and presence (Goleman 1996). Goleman's model comprises five main elements: self-awareness, self-regulation, social skills, empathy and motivation. He asserts that each can be developed to achieve outstanding performance.

Among the differing definitions and domains of EI, Kooker *et al.* (2007) suggest that the three primary models (Salovey & Mayer, 1990, Bar-On 1997 and Goleman 1996) share four commonalities albeit worded slightly differently: self-awareness, self-management, social awareness and social/relationship management. This is important to establish in the context of this discussion especially in relation to defining the values in VBR.

Patterson (2011) conceptualises EI as ‘the capacity to recognise our own feelings and those of others; to manage emotions effectively in ourselves and in our relationships; motivation; creativity; the ability to perform at an optimal level at work and persist in the face of adversity’. Akerjordet & Severinsson (2007) suggest EI attempts to define an ability to combine emotions with intelligence and use emotions in a constructive problem solving and decision making way. They assert that EI implies important personal and interpersonal skills in the use of the ‘self’; being aware of what one is feeling and being able to act and respond appropriately (Akerjordet & Severinsson 2004). Jordan & Troth (2002) suggest that emotional awareness and emotional management are key components of emotional intelligence. Lopes *et al.* (2006) describes an association between emotional intelligence and social interaction. He suggests that emotions serve communicative and social functions, conveying information about people’s thoughts, intentions and contributions to social encounters.

Lopes *et al.* (2006) critiques the epistemological foundations of the construct of emotional intelligence by acknowledging that cultural differences in emotional expression will have an impact on the reliability and validity of any tools attempting to quantify ‘it’. This is particularly relevant in VBR where EI assessment is not recommended because of the lack of consensus about what the term means. Emotional labour, emotion work, professional closeness, the ‘therapeutic use of the self’ all refer to dynamic features that are embedded in the caring relationship between a midwife and a mother. How these are described in the

context of personal qualities is problematic. EI has emerged as a construct which attempts to give language to these personal qualities. EI theories have captured professional and lay people's imagination and attention, not least because they appear to embody an approach to interaction with others which people can relate and aspire to. Referring to the lack of consistent conceptualisation, critiques have questioned EI theories (Lewis *et al.* 2005, Waterhouse 2006). Cherniss *et al.* (2006) do not consider this to be a reason to discredit EI suggesting that at the early stages of theoretical development the generation of different versions of theory is not indicative of weakness but a sign of validity. Waterhouse (2006) counters this argument suggesting that the differing EI definitions demonstrates that it is poorly understood and therefore generalisations across studies are not possible. Whatever the phrasing or definition of EI, the need for a midwife to be able to offer women care enhanced through 'emotional awareness' is clear.

The 'emotionality' implicit in the relationship between a woman and her midwife is difficult to define. Phrases like 'emotion work' and 'emotional labour' (Hochschild 1983), 'emotional engagement' (Deery 2009) and 'emotional intelligence' (Goleman 1996, Patterson 2011) refer to different aspects of this 'emotionality' and they can be used interchangeably in the literature, see Table 1. This adds to the complexity of making empirical judgements about whether an individual possesses the personal values that align with being able to engage in this 'emotionality' and can it or should it be captured in a VBR framework?

Implications for Midwifery: VBR and 'Emotionality'

While the meaning of the term 'values' is alluded to in the key documentation which explains the role and responsibilities of a midwife, it is not consistently used or defined. What can be identified in the competency frameworks of the NMC (2009) and the ICM (2011, 2014) is an intrinsic thread centred on the 'relationship building' between carer and health care

professional. The NHS Constitution values encompass much that is important to those requiring health care services. However, there is no mention of emotions/emotionality or emotional responsiveness which women consider to be important to them.

We acknowledge that the relationships between a woman and her midwife or a patient and their carer are complicated as much by the relationship itself as by other institutional factors where they occur (Francis (2013). Midwives working in the health service face the challenge of competing expectations and demands. Exemplifying Schwartz's values theory, they are required to meet women's needs and reflect the ideology of providing 'woman centred care' while practicing in healthcare systems which endorse 'efficiency', targets and standardisation of care (Hunter 2004). The potential tension that this situation evokes is recognised (Rankin *et al.* 2013) and it may result in cognitive-blindness (Paley 2014) and moral distress (Banks & Gallagher, 2009, Mauno *et al* 2016). Occupational 'burn out' (Sandall 1998, Hunter & Deery 2009) associated with a dissonance between an outer portrayal of feeling (socially acceptable displays of emotions) and inner emotions, has also been identified amongst caring professions. This conflict can result in depersonalisation and suppression of internal feelings and 'burn out' (Hunter & Deery 2009). Research (McAllister and McKinnon 2009, McDonald *et al.* 2016) supports the importance of self-reflection techniques to mediate against the effect of professional burnout when meeting the demands of health service provision.

Selection of the future midwifery workforce, indeed all caring professions, not only has to consider 'what' are the desirable personal values but situate these alongside identifying those individuals who possess the potential to be able to manage competing demands. Important to this, is the need for an individual to be 'self-aware'; to be able to recognise their own values and aspirations and how they can impact on the care they provide (Karimi *et al.* 2013).

Central to VBR processes are NHS Constitution (DH, 2012) values. We suggest an enhancement of the compassion value to read:

‘We ensure that compassion is central to the care we provide and we respond with humanity, ‘*sustainable emotionality*’ and kindness to each person’s pain, distress, anxiety or need’.

‘Sustainable emotionality’ meaning: ‘A carer’s ability to engage with people in a healthcare relationship which features emotional engagement, sensitivity and responsiveness, self-reflection and self-awareness; to foster a ‘caring moment’ which is perceived as authentic by the recipient and is sustainable by the care provider.

The ‘sustainable emotionality’ conceived in this paper is different; it incorporates some of the personal qualities associated with EI as well as features of care and compassion but includes a sustainable dimension so important in today’s health service (Hunter 2009). The fluidity of the conceptualisation is emphasised; a responsive, sensitive midwife will engage with a woman in a way that meets the woman’s needs. Some women might value a deeper engagement, others more superficial but it is the skill of the midwife to be able to be sensitive to this and respond appropriately.

CONCLUSION

This paper is about acknowledging emotions in health care relationships and situating them in a theoretical framework. An apparent omission in the current considerations of VBR is highlighted where an enhancement to the core values is suggested. Noteworthy is the relevance of this discussion to all health care relationships. Peplau’s (1952) seminal considerations are written from a nursing perspective. We argue that it is important to acknowledge the generic relevance of this ‘softer’ side of ‘care’ because emotions impact on

human behaviour and arguably affect each and every one of us. Further empirical research is needed to evaluate how VBR is conceptualised and adopted to inform selection process to caring professions and whether those selected are able to health service users' needs ensuring the continuance of high quality care provision.

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