Part 1 Introduction and theory

Chapter 1

Values-based practice in health care: setting the scene

'If there is any merit in this idea at all, the VDM (values-based decision making) offers a hugely exciting prospect for greater tolerance and understanding between human beings.' *(Seedhouse, 2005, page 47)*

Values-based health and social care practice is an approach that aims to involve both patient and professional in decision making and management, taking into account both parties' views. It may be seen as complementary to what are claimed as the more scientific aims of evidence-based practice, which some practitioners and patients consider has reduced rather than enhanced the possibility of patient partnership. There is an emphasis in the health professional literature, particularly from medicine, on evidence-based practice often without a mention of values. In this chapter I will explore the nature of both values-based and evidence-based practice in general, while chapter 2 considers values as they affect teamwork and collaborative practice.

Definitions of values

One definition of values is that they 'operate as standards by which our actions are selected' (Mason et al., 2010, page 71). Also succinctly 'a value is a belief upon which man acts by preference' (Allport, 1961, page 454). In relation to patients, values are 'the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient' (Thornton, 2006, page 2). Fulford et al. (2012), in the first volume of this series, use the term 'values' to include 'anything positively or negatively weighted as a guide to health care decision-making'. Values-based care or values-based practice (VBP) similarly has a number of definitions (Box 1.1).

Many of the definitions arise from work involving mental health services. For example the National Institute for Mental Health in England (NIMHE – now known as the National Mental Health Development Unit NMHDU) has developed a national framework of values for mental health, guided by three key principles of values-based practice. These principles are recognition, raising awareness and respect for diversity. The framework stresses that values as well as evidence must be recognised as having a role in mental health policy and practice. Professionals need to be aware of differences in values and how these may affect their practice in mental health. This diversity should be respected to ensure not only equality but to avoid discrimination for any reason such as age, gender, cultural background, sexuality, religion or

Box 1.1: Definitions of values-based practice

'…a blending of the values of both the service user and the health and social care professional, thus creating a true, as opposed to a tokenistic partnership' (Thomas et al., 2010, page 15).

'The theory and capabilities for effective decision making in health and social care that builds in a positive way on differences and diversity of values' (University of Lincoln, online).

Fulford et al. (2012), in the first volume of this series, define values-based practice as consisting of a premise, process and point. Starting from the 'democratic' premise of mutual respect for differences of values, they describe a 10-part process to achieve the 'point' of balanced decision-making within frameworks of shared values.

race. Respect for values is a reciprocal process: the patient and all involved in care including the different professionals, carers and health services have to be aware of and respond to values, taking them into account in diagnosis, management and follow-up.

The importance of VBP has been recognised by its inclusion as part of the UK Royal College of General Practitioners' (RCGP) curriculum for British general practitioners. This states that all GPs should be able 'to understand the nature of values and how these impact on healthcare' (RCGP, online). Moreover, GPs should be able to 'recognise their personal values and how these affect their decision-making'.

Reflection point

If you are new to the concept of values, or haven't really thought about your own definition, pause to consider what you and other people might mean by 'my values'.

You will probably use some of the following words and terms: principles, beliefs, ethics, standards, conscience, virtues.

A value can be a belief, a mission, a motivating force, an ideal or a philosophy that has meaning for an individual, community or organisation. An individual may not be aware of holding, choosing or developing these values until challenged, or put into a situation where others have different or opposing values, leading to potential conflict. When asked to define your own values, you may also include words or terms that refer to some of the actual values that you do hold: being fair, telling the truth, kindness, respect, obeying the law, being a hard worker, helping people less fortunate than yourself, altruism, integrity, loyalty, self-reliance, putting family first. You may think of professional values such as being punctual, being smartly dressed, being a good communicator, not breaking confidentiality, putting the patient first, going that extra mile for the patient or community; all very positive. But your value-system might also include a darker side: making sure you get your rights, aiming to be better than others, striving to come top of the class, doing whatever it takes to succeed. I have labelled these 'darker' but that is my value judgment and certainly not everybody's.

The diversity of values

If you now ask the question, what do I value most in life, your list may include other items such as: my family, my health, job, colleagues, religion, car, exotic holidays etc. This shows the power of one English word and the connotations it can hold. Value, and its adjective valuable, is also used to mean monetary worth, though something may have sentimental

value to one person, while being worthless to another. In certain societies everything may have a price: loyalty, affection, trust, until a higher bidder comes along and there is a transfer of such attributes for greater profits. Thus saying that something is valuable to me has little meaning unless the context is clear. I may say to a colleague 'I value your opinion' until I hear what that opinion is and belittle it, negating my previous statement and showing that I only value their opinion if it resonates with my own. On the other hand I may listen to their opinion and find it very useful.

A group of people that looks homogeneous from the outside may be made up of individuals with very different values. We often assume that people we like, we work with, who are on our team, who are in the same profession, whom we respect, have similar values to our own, but it is not something we usually explore when making acquaintances, or working with new colleagues or when we join a new team: we usually pick up on their values in our interactions, and they pick up on ours.

The Australian Government Department of Immigration and Citizenship gives a list of Australian values that I had to commit to when becoming an Australian citizen (Box 1.2).

Box 1.2: Values of Australian citizens (Australian Government, 2011)

- Respect for the freedom and dignity of the individual
- Equality of men and women
- Freedom of religion
- Commitment to the rule of law
- Parliamentary democracy
- A spirit of egalitarianism that embraces mutual respect, tolerance, fair play and compassion for those in need and pursuit of the public good
- Equality of opportunity for individuals, regardless of their race, religion or ethnic background.

The department goes on to state that 'although these values may be expressed differently by different people, their meaning stays the same. The values may not be unique to Australia, but they have broad community agreement and underpin Australian society and culture'. Apart from parliamentary democracy being irrelevant in the health context, there is probably nothing here that a health professional would disagree with, but there could be conflicts with others in the way we interpret the values and there are other values that might also underpin our work.

We make value judgments every day: from the mundane (is this computer worth this much to me?) to more important decisions which may have profound effects (can I trust this doctor? Can I trust this health professional? Can this patient make an informed consent?) When considering such judgments, we need to have a choice of behaviour. If there is only one option, there is nothing to judge, unless there is the option to do nothing.

How do we know what our values are? How do we develop or acquire our values? We acquire our personal values early in life and develop them as we mature; they shape and influence how we think and what we do (Warne & McAndrew, 2008). We may not be aware of them until we are tested. Mason et al. (2010) have suggested that 'identifying one's values requires a person to decisively penetrate their moral index and form a values inventory' while stating that 'in reality, most people are living the values of others' (page 73).

We may think we hold values but we may soon lose some of these when tested (as before: everything has a price). I may hold the value that stealing is wrong, but not speak up if given

too much change when shopping, or not declare that extra bit of untaxed income to the Inland Revenue. In the latter case, my value of honesty is outweighed by my belief that it is perfectly ok to try to pay less tax using any means possible.

Most of the time we are not aware of our values in our choices, but when we are faced with conflicting values we may become uneasy, and decisions are likely to be more difficult. There may be conflicts between our own values, or between our values and others we interact with. For example, a health practitioner's professional values may include thinking that using marijuana is wrong as it is illegal and harmful; however his personal values based on experience, preference and other evidence lead to his using the drug at social events. A person might say that one should always tell the truth, but finds this difficult in situations where the truth might hurt someone, such as when giving a prognosis or commenting on appearance. Conflicts between patients and professionals, and between two professionals, can arise due to major ethical clashes (a health professional does not agree with termination but the patient is requesting this; a doctor agrees with euthanasia but a nurse does not) to issues that are more irritating than profound (I always finish a task staying on past 5pm at work if necessary, but my colleague is out the door 5 minutes before time to beat the car park rush). Volunteering or sticking up for one's values may be difficult in situations where there is a power differential. If your boss is always checking emails on his phone while you are talking to him, what can you do? But you would probably tell your 14 year old son not to do this.

Personal values are learnt through experience, through education and role modelling. As children we may at first assume our parents' and then our teachers' values. Later we are assaulted by a number of competing forces that may alter or reinforce our values. We learn what the consequences of our values-based choices are and decide to change these values. We mature.

If we change our behaviour in order to conform within the environment in which we work or live, but do not change our values we may become unhappy or burnout. For example, if we work within an office where it is acceptable for people to make sexist comments because no one challenges these, and everyone joins in, we may also laugh at the jokes while cringing inside. Eventually we either become acculturated to the behaviour or we continue to feel uneasy and feel discomfort at work. In the health care setting, profession X may make regular disparaging remarks about profession Y. As a member of X I do not initially join in, but neither do I stick up for Y, or challenge the remarks. I feel uncomfortable that I cannot uphold my values of fairness and equity, but am worried that I will be ostracised in the same way if I speak up. Members of Y probably think I am just like all the X's. Eventually I become a stereotypical X or have to move on. Similarly we may become immune to black humour and making fun of patients or health care situations. Older professionals may tell students that this is one way of dealing with stress and that, if kept within the profession, it will hurt no-one. But we do not work in professional silos, and we also work with non-professionals who make take great offence at this 'harmless fun'.

An important factor influencing learnt behaviour like this is the concept of what is called the 'hidden curriculum' (Hafferty & Franks, 1994) in relation to education, but which may be applied to any situation where learning from others may occur. In contrast to the intended or formal curriculum (what I intend learners to learn and which is explicit in terms of learning goals or outcomes), the hidden curriculum is learning by immersion, observation and role modelling. The hidden curriculum is 'the medium by which values and mores are transmitted, operates at many levels (from institutional down to an individual learning situation),

and is without doubt one of the most powerful and unrealised influences on professional development' (Thistlethwaite & Spencer, 2008, page 166).

Communities, cultures and organisations may hold values in common. At some point these may have been discussed and agreed on by a majority of members. Later members are then assumed to agree with the values by virtue of their membership. An organisation may have a defined mission statement that all members learn about during induction; a community may have a code of conduct which if broken leads to punishment. However sometimes the communal values are not obvious until breached, and in defence an individual may state that she didn't know that what she did was wrong.

Professional values

Reflection point

What do you consider to be your profession's values? Do they differ from your personal values? Has anyone ever asked you what your professional values are? (Perhaps at interview?)

How do our professional values differ from our lifestyle and moral values? According to one management website (http://www.officearrow.com/job-satisfaction/what-are-your-professional-values-oaiur-636/view.html) professional values 'are the principles that guide your decisions and actions in your career'. We will consider later how values might differ between professions, but there is probably a core set with which all health and social care professionals would agree. This particular website calls these universal values, which should be held and practised within all professions. There are five (Box 1.3). Moreover, a failure to adhere to these values is believed to be a major cause of the economic and social damage that devastated the global economy in 2008.

Box 1.3: An example of professional values

- First, do no harm.
- Keep it simple.
- Honesty is the best policy.
- We're all in this together.
- Stay balanced.

The aphorism 'first, do no harm' is credited to Hippocrates, the father of medicine, and could be the motto of the patient safety movement. While this phrase was written in relation to not harming patients, we must also avoid harming our colleagues. We can harm both by commission and omission. To lessen the risk of harm health professionals learn to reflect-in-action: is what I am doing or planning to do likely to cause more harm than good? Sometimes in the heat of acute medical care there is little time to reflect, and little time to communicate, a potent cause of error.

Keep it simple: this may seem an impossible task in the modern complex world of patient care. The management angle on simplicity refers to transparency and openness. In health care this translates as professionals having an understanding of the roles and responsibilities of their colleagues: without this understanding should we be attempting to work together? If there is duplication of roles, we need to consider how best we might combine our efforts. When talking to each other while working, making referrals, discharging patients from one

care-giver back to another, there should be clear language and explanations. There should rarely be the moment when one professional has to wonder: why he is doing that, why did she do that? If in doubt, ask. When asking a colleague to carry out a task, explain its purpose. Consider the possible advantages and disadvantages of each course of action, each step in the management plan. What are the possible benefits and risks? What risks are you, your colleagues and the patient prepared to take? Simplicity is also a key to good patient-professional communication: avoiding jargon and checking understanding.

Honesty is the best policy: being truthful is a commonly held value. Yet many of us use the 'little white lie' as a way out of difficult interactions. Being honest can be hurtful, and caring professionals are loathe to hurt and certainly to reduce hope. We say someone was brutally honest, suggesting that there are degrees of honesty. Consider the last time you were less than honest – would you translate this as actually lying? We say such things as: this won't hurt; there is nothing to worry about. If I don't list all the possible side effects of a medication, am I being honest? With colleagues we might say: you handled that quite well (but really we mean it could have been done better). Sometimes rather than be honest, we give feedback in different ways. If I am not happy with the way another health professional has dealt with *my* patient rather than tell them, I don't refer to that person again.

We're all in this together: can be read in many different ways. Perhaps it puts the onus on the professional to campaign for social justice and health equality. Perhaps it means we should think ecologically, about waste, about health costs. Or perhaps this reflects the values of professionalism that stress in times of difficulty we close ranks, we protect our own and we denigrate whistle-blowers. One of the six elements of a profession has been defined by a sociologist as organisation of members (Johnson, 1972). This organisation may also be regarded as professional autonomy and self-regulation, which some regard as a professional value:

> 'The central element of professional autonomy is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients . . . as a corollary to the right of professional autonomy, the medical profession has a continuing responsibility to be self-regulating . . . the medical profession itself must be responsible for regulating the professional conduct and activities of individual physicians' (The World Medical Association, 1987, online).

Values change and now in many countries such as the UK, the regulatory body includes lay representatives who judge professional conduct.

Balance: as health professionals we should role model good health practices, including the work-life balance. We teach self-care to health professional students, and then wonder why they do not want to work long hours, or stay late to ensure their patients have some continuity of care. But for our own well-being we do need to balance our clients' needs and our own. We also need to balance our colleagues' needs, the team's needs and our family's.

Examples of professional values

What are the similarities and differences in values between health care professions? We can explore these in part by looking at the documentation of health professions containing their stated values or principles of good practice.

For doctors in the UK the General Medical Council has a number of publications focusing on good medical practice. These include the duties of a doctor, which incorporate values

(Box 1.4). The GMC also now states that doctors must inform the council if they believe a colleague is unfit to practise. This 'telling tales' may go against some doctors' values.

Box 1.4: Duties of a doctor – selected examples (General Medical Council, 2002)

- Make the care of the patient your first concern.
- Treat every patient politely and considerately.
- Respect patients' dignity and privacy.
- Listen to patients and respect their views
- Respect the rights of patients to be fully involved in decisions about their care.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure that your personal beliefs do not prejudice your patients' care.
- Avoid abusing your position as a doctor.
- Work with colleagues in the ways that best serve patients' interests.

In one study nurses have identified human dignity, equality among patients and prevention of suffering as their top ranking professional values (Rassin, 2008). These resonate with the Australian Code of Ethics for Nurses, which lists eight items that nurses value (Box 1.5). There are obvious overlaps between nursing and medicine. The allied health professions have similar statements but there is not enough room to list all of these.

Box 1.5: Code of ethics for nurses (Australian Nursing and Midwifery Council, 2008)

Nurses value:

- Quality nursing care for patients.
- Respect and kindness for self and others.
- The diversity of people.
- Access for quality nursing and health care for all people.
- Informed decision making.
- Cultures of safety in nursing and health care.
- Ethical management of information.
- A socially, economically and ecologically sustainable environment promoting health and well-being.

The 10 principles of values-based practice

There are 10 principles of VBP under four headings (Box 1.6). I will consider the implications of these in the context of interprofessional teamwork.

Health professionals need to be aware of the values in a given situation; this also means not assuming what someone's values might be. When in doubt, ask. It is easy to make a value judgment about other people, and other professionals, leading to miscommunication which may not be apparent straight away but which may ultimately cause difficulty with sharing care and decisions. Reasoning then is about thinking of these values when making decisions. We need to know about values and facts that are relevant to a situation, and have some knowledge about how the professions might differ in their professional values as members of multidisciplinary or interprofessional teams. Good communication helps resolve conflicts.

Box 1.6: The 10 principles of values-based practice (Fulford, 2004; Woodbridge and Fulford, 2004, page 20)

Practice skills

1. Awareness: of the values present in a given situation.
2. Reasoning: using a clear reasoning process to explore the values present when making decisions.
3. Knowledge: of the values and facts relevant to the specific situation.
4. Communication: combined with the previous three skills is central to the resolution of conflicts and the decision making process.

Models of service delivery

5. User-centred: the first source for information on values is the perspective of the service user.
6. Multidisciplinary: as in teamworking (see also interprofessional).

VBP and Evidence-based practice (EBP)

7. The two-feet principle: all decisions are based on facts and values.
8. The 'squeaky wheel' principle: we only notice values when there is a problem.
9. Science and values: increasing scientific knowledge creates choices in health care, and therefore wide differences in values.
10. Partnership: decisions are taken by service users and providers of care in partnership.

The 'two feet' principle is that all decisions are based on facts and values. Evidence-based practice and values-based practice are complementary and both need to be considered. Can you think of instances where professionals use different evidence bases because of their different literatures and research approaches? The 'squeaky wheel' principle is that values shouldn't just be noticed if there's a problem.

Increasing scientific knowledge creates choices in health care. This can lead to wider differences in values. Shared decision making is important when there is choice – shared between patient and professional, and between the different professionals involved in partnership. This may not be as easy or uncontroversial as it sounds. In particular the professionals may not work in partnership together for a number of reasons, which we explore in this book.

Patient-centred practice

VBP should be a fundamental part of patient-centred care, and indeed the two approaches may be considered to be very similar. A major difference is that patient-centred care 'centres on the patient', encompassing an exploration of the patient's values but not specifically the professional's.

At this point, it is worth considering the meaning of patient centredness, a term that is not easily defined. The patient-centred approach to patient-professional interaction is based on the premise that a patient's problem may be defined in terms of its physical, psychological and social components, what has been called the biopsychosocial model (Engel 1960; 1980); more recently some practitioners are also adding the dimension of spirituality. Nearly 30 years ago in the classic text about general practice consultations, the recommendation to explore a patient's ideas, concerns and expectations became linked to patient centredness; thus: '…it would seem that satisfaction of the patient is more likely when the doctor discovers and deals with the patient's concerns and expectations; when the doctor's manner

communicates warmth, interest and concern about the patients, when the doctor volunteers a lot of information and explains things to the patient in terms that are understood' (Pendleton, 1983, page 45). To these three elements we are now adding values, but with the extra emphasis on sharing of values, in a two-way reciprocal process.

The easiest way to define patient-centredness relies on tautology: it involves putting the patient at the centre or focus of the interaction. In the next chapter on teamwork, we will also find that we are exhorted to put the patient at the centre of the team. Yet, if we are aiming to build a partnership, 'a meeting between experts', and the patient is in the centre, where is the professional?

The expert patient

The idea of the patient as an expert was put forward in the 1985 book *Meeting between experts* (Tuckett et al., 1985) and focused on shared understanding between patient and practitioner. The patient was defined as an expert about his or her illness. The doctor, in this case, would ask about a patient's ideas about the illness or problem, he or she would then tap into this expertise and share his or her own professional diagnosis of the problem in turn with the patient. The result should be shared understanding, with both parties being aware of any points of conflict and differences between each other. Of course we now know that some of this conflict arises from disparate values, which are not specifically mentioned.

Communication skills training is now a major part of health professional curricula. Practitioners learn how to be patient (or client) centred. However, many patients remain unused to interacting in such a way. They, of course, receive no formal training in such interactions: they learn on the job, in the consultation, from the cues they are given about what may or may not be discussed. Many patients also worry about wasting a doctor's time with problems they perceive as non-medical (Bensing, 1991). When asked to share ideas, concerns and values, patients may find it difficult to express these, and their feelings, particularly if they do not do this regularly. Skilled professionals should be more able to put patients at their ease and facilitate two-way communication. But even these practitioners may not be used to considering how their own values impact on the care they deliver.

Barriers to VBP

As good communication is a necessity for VBP, the barriers to VBP are also the factors that impede communication. These factors can be thought of under three headings (Thistlethwaite & Morris, 2006).

Professional/practitioner factors

The predominant barrier is lack of training and lack of awareness of the different approaches to improving communication. Professionals may also focus on the tasks of the consultation/interaction such as health promotion and diagnosis, and neglect the process such as establishing rapport and involving patients in decisions. Some practitioners are reluctant to explore patient concerns because of worries about feeling powerless or overwhelmed by patients' problems. This feeling may be heightened if the professional has trouble dealing with uncertainty, lacks empathy and/or feels burnt out.

Patient factors

Patients, on the whole, need to be invited to discuss their concerns and values. They are usually reticent in volunteering information when the professional is eliciting a formal medical history. As noted above they may be concerned about wasting the practitioner's time. Their values may be very personal and not something they have much practice in discussing. They may be embarrassed to divulge values, particularly if they consider them likely to be at odds with those of the person they are consulting.

Organisational factors

The main barrier is time. Consultations in general practice tend to be fairly short: up to 10 minutes with a GP, maybe 20 minutes with a practice nurse, possibly more with other health professionals for treatment, e.g., physiotherapy, counselling, social work. Professionals often feel frustration with lack of resources; inviting patients to discuss concerns and share decisions, taking into account ideas and values, result in a management choice that is not feasible within the local health service.

Evidence-based practice

VBP complements evidence-based practice, though the latter is usually referred to as evidence-based medicine (EBM), reflecting the biomedical positivist culture, with its emphasis that all clinical decisions and management plans should have supporting evidence.

A useful definition of evidence-based medicine (EBM) is:

> '…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer'.
>
> (Sackett et al., 1996)

Note the reference to patients' predicaments, rights and preferences rather than values.

Thus, according to the EBM movement, all investigations and treatment should be evidence based. Problems arise when there is no evidence, it is conflicting or potentially out-of-date. The evidence may also recommend management that is not available in the local health service, is considered too expensive and unlikely to be funded, or is outside the professional's area of expertise. The 'best' option may not always be what the patient would choose, but this raises the question as to who defines 'best'.

Health professionals are expected to keep up-to-date with advances in medical knowledge and published evidence. But the speed with which the discipline is changing makes it almost impossible for generalists, such as work in primary care, to be abreast of all recent