Part 1

Values, individuals and an overview of values-based practice

Introduction to Part 1

In this Part 1, we set out by way of introduction a number of key ideas respectively about values, individuals and values-based practice and the tools we have for working with them in medicine and healthcare.

- Chapter 1 is about values in clinical decision-making. It sets the scene with three key points about values as these emerge from the opening scenario in a consultation for chronic low back pain between a GP, Dr. Gulati, and her patient, Roy Walker.
- Chapter 2 is about individuals. It takes us to the starting point for values-based practice in the complex values that bear on individual clinical judgment in clinical decision-making. Again, we get to these complex values not in a theoretical way but by following a further stage in Dr. Gulati's story as she works through some of the tools in medicine's values toolbox (professional codes, ethics, decision analysis and evidence-based practice).
- Chapter 3 gives an overview of values-based practice setting out briefly its point (it is about balanced decision-making), its premise (in mutual respect) and ten elements of the process by which it supports clinical decision-making in practice. The chapter also includes examples of how values-based approaches have been developed and applied in various areas of mental health.

Part 1 as a whole thus paves the way for the more detailed description of values-based practice that follows in the rest of the book. The chapters in Parts 2–4 illustrate a number of key elements of values-based practice considered separately, while Part 5 shows how these elements come together in practice.

Part 1

Values, individuals and an overview of values-based practice

Chapter 1

"It's my back, Doctor!" (episode 1): values and clinical decision-making

Topics covered in this chapter

Three key points about values in medicine are outlined as illustrated by a GP consultation for chronic low back pain between Dr. Gulati and her patient, Roy Walker.

Other topics include:

- Ethical and other values
- Clinician and patient values
- Foreground and background values
- The network of values
- Values, decisions and actions
- NICE guidelines for low back pain.

Take-away message for practice

*Values in medicine (i) include but are **wider than ethics**, (ii) are **everywhere** and (iii) are **action-guiding**.*

Values-based practice, as we indicated in our introduction, is a new skills-based approach to working more effectively with complex and sometimes conflicting values in medicine. As such, values-based practice is like evidence-based practice: both are responses to the growing complexity of clinical decision-making. Evidence-based practice supports clinical decision-making where complex and sometimes conflicting *evidence* is in play. Values-based practice supports clinical decision-making where complex and sometimes conflicting *values* are in play.

In this chapter, we illustrate the complexities of values in medicine not with a high-profile "ethics case" but rather as they emerge from the everyday scenario of a GP consultation for chronic low back pain. Three key points will emerge from this scenario, namely that values in medicine:

- are *wider than just ethics*, which nonetheless are an important aspect of our values;
- are *everywhere in medicine*, although not always recognized for what they are;
- are important because they stand alongside evidence in *guiding decisions and actions*.

In Chapter 2, these three key points about values in medicine will take us (still with the story of Dr. Gulati and Roy Walker) to the starting point for values-based practice in individual clinical decision-making.

The clinical context

Roy Walker, a 36-year-old laborer with a poor work record and a history of alcohol abuse, walked into Dr. Rushi Gulati's consulting room as the first patient in a busy Monday morning clinic saying, "I've come for my sick note." Roy Walker was normally seen by a different partner in the practice, Dr. Austin, who had a relatively relaxed attitude to off-work certification. However, Dr. Austin was on 2 months' study leave.

Dr. Gulati saw from Roy Walker's notes that he had been receiving increasingly strong analgesics for low back pain for some months following a strain at work. Repeated investigations had, however, been negative, and Dr. Gulati's examination on this occasion showed no significant clinical signs. When she tried to explain this to Roy Walker and to suggest ways of starting to get himself back to work, he became agitated and refused to leave "until I've got my usual."

The variety of values in the clinical encounter

The complexity of the values base of decision-making in current practice is clearly evident in this opening clinical scenario between Roy Walker and Dr. Gulati. The standoff that is developing between them is not the stuff of high-profile ethical debates. Yet into this familiar, perhaps all too familiar, situation of everyday clinical experience are packed many of the different kinds of values we encounter in health care.

Reflection point

Before reading on, you may want to think for a moment for yourself about the variety of different kinds of values that are important in health care. Some of these are mentioned in our introduction but you may find you think of others as well.

Which of these different kinds of values are in play in the opening scenario between Roy Walker and Dr. Gulati?

Dr. Gulati's values

First, there are clearly ethical issues for Dr. Gulati. Some of these are general ethical issues, around honesty and fair-dealing for instance. There are also specifically medical ethical issues: Roy Walker was demanding "his usual" and autonomy of patient choice is an important principle of patient-centered practice to which Dr. Gulati was committed. But she was also equally committed to the principle of acting in her patient's best interests, which, in this instance, given the clear evidence of poor outcomes from chronicity (see below), seemed to be pushing her towards refusing his demands.

However, there are also values of many other kinds bearing on Dr. Gulati. Thus, the evidence of poor outcomes with low back pain just noted is relevant also to quality-of-life issues, and to the quality of life not just of the patient but of the patient's family. In the present case, Dr. Gulati was well aware of the implications (positive and negative) for Roy Walker's wife and children of how she responded to his demands.

Then again, Dr. Gulati was conscious of the fact that she and other partners in the practice had worked hard to establish a rigorous approach to clinical governance, and that in a recent practice audit, Dr. Austin's willingness to issue off-work certificates on apparently tenuous grounds had stood out like a sore thumb. There was also "value for money" to think about – the practice had recently been celebrated in the local media for providing a first-class clinical service within tight budgetary controls based on evidence-based prescribing.

The variety of values in general

We should not be surprised by the variety of values bearing on Dr. Gulati in this opening scenario from her consultation with Roy Walker. The Scandinavian philosopher Georg Henrik von Wright devoted a whole book to exploring the varieties of values (von Wright, 1963). This indeed is an important aspect of the complexity of values that, as we noted in the introduction to this part of the book, lies behind the need for values-based alongside evidence-based approaches in medicine.

Faith Internalization Acting in best interests	How we treat people Attitudes Principles
Integrity Conscience Best interests Autonomy	Autonomy Love Relationships
Respect Personal to me Difference . . . diversity	Non-violence Compassion Dialogue
Beliefs Right/wrong to me What I am	Responsibility Accountability Best interests
Belief Principles Things held dear	What I *believe* What makes me tick What I won't compromise
Subjective merits Meanings Person-centered care	Objective "core" Confidentiality Autonomy
A *standard* for the way I conduct *myself* Belief about how things should be Things you would not want to change	Significant Standards Truth

Fig. 1.1. What are values?

Fig. 1.1 illustrates a further aspect of the complexity of values in medicine. It shows the wide variety of different meanings associated with the very word "values" by a group of trainee doctors.

The triplets of words in this table were produced as part of an exercise during a training workshop on values-based practice. Everyone was asked to write down "three words or short phrases that mean 'values' to you." As an exercise in word association, the task aimed to be personal and individual. Thus, the triplets of words show what each of the trainees individually associated with the word "values" rather than trying to come up with anything in the way of a consensus.

As you can see, although there were some shared meanings, everyone came up with a different set of

words. The variety of meanings associated with the word "values" by just this one small group of trainees included as you might expect ethical values – "principles," "right/wrong to me," "standards," etc. as in Fig. 1.1; but they also included needs ("things held dear"), preferences ("personal to me", "what makes me tick"), hopes and ideals ("belief about how things should be") and a wide selection of specific values ("compassion", "loyalty", "faith", etc.). There are still further kinds of values that are not even represented in the table, such as cultural and aesthetic values and prudential values (wise, foolish).

Key point 1: values are wider than ethics

Fig. 1.1 thus takes us straight to the first key point about values that we need to be aware of clinically, namely that *values are wider than just ethical values*. Health-related values *include* ethical values, of course, and we will be seeing later how ethical and other values come together in clinical decision-making. But health-related values include much else besides.

Values are everywhere in the clinical encounter

Besides the sheer variety of health-related values, it is important to be aware of where and how and (crucially) *whose* values are involved in the clinical encounter. Again, this is well illustrated by the opening scenario between Dr. Gulati and Roy Walker.

Reflection point

You may want to go back to the opening clinical scenario between Roy Walker and Dr. Gulati at this point.

We have noted the *variety* of values in play. But exactly *whose* values are important here? And where and how do they come into the clinical encounter?

Meet Roy Walker

One way to think about these questions is in terms of the individuals most directly involved. In the last section, we focused on the values bearing on Dr. Gulati. But the clinical encounter is, of course, a *two*-way encounter. So it is the *interaction* between Dr. Gulati's values and Roy Walker's values that will determine how the consultation goes.

Roy Walker has thus far come across to Dr. Gulati as an obstreperous and bullying man who is at best a hypochondriac and at worst simply work shy. Certainly, he is potentially aggressive. But behind the bluster, as we will see when we return to their story in Chapter 14, is a man who had always lacked confidence and whose self-esteem had suffered a further severe blow with his back injury and (as he saw it) his inability to work. As a younger man, Roy Walker had been athletically built, and much of his fragile sense of self-worth was invested in his well-muscled physique. Now, with a developing "middle-aged spread" since he had stopped working, even this seemed to be slipping away.

Correspondingly, Roy Walker, whose only successes in life had been achieved by rather aggressively asserting himself, reacted in the only way he knew how when he found himself in front of Dr. Gulati instead of Dr. Austin. He was in fact very much aware that he needed help (we look at why this was so in Chapter 14) but, in his culturally influenced perception, "maleness" did not go with talking about your problems. Notwithstanding this, he had been plucking up courage to ask for help from Dr. Austin and had thus been completely taken aback to find himself seeing not only a different doctor but a female doctor. A more self-confident man might have managed this set-back better. But for Roy it felt as though he could never win.

Added to that, his appearance was against him. Demoralized and unhappy man that he was, he had clung on to his self-image as a strong man by wearing vest-style T-shirts to show off his bull-like shoulders. Dr. Gulati was wrong-footed by this. Partly she was concerned about physical violence, although she prided herself about taking no nonsense from bullying men. Partly also her deep-rooted aesthetic and cultural values contributed to her finding his appearance rather distasteful. As she became aware of this, she was able to mediate this "personal taste" value by reminding herself how her experience as an Asian woman had taught her just how damaging it could be to be judged by appearances. Professional objectivity was thus also an important value for Dr. Gulati.

Clinician *and* patient

In the clinical encounter, then, the values of both clinician and patient are important. This might seem obvious. But it is a point worth emphasizing in the context of current policy and service development priorities that increasingly emphasize "patient power."

These priorities reflect a perceived need to shift away from a traditional emphasis on professional power, sometimes characterized as "the doctor as God." However, the shift risks taking us to the opposite extreme of "the patient as God," a consumerist model in which the patient, like a customer, is always right.

Values-based practice, as we will see in Chapter 3, seeks to avoid these extremes with an approach that starts from a premise of mutual respect and relies on a robust process to support balanced decision-making in the particular circumstances of the particular individuals involved in a given clinical decision.

Foreground and background values

Digging a little deeper into our opening scenario also makes a further point about the ubiquity of values in medicine, namely that they are not all equally self-evident – there are, as it were, background values as well as more obvious foreground values in the clinical encounter.

In the present case, Dr. Gulati's commitment to evidence-based prescribing and Roy Walker's wish for an off-work certificate are both foreground values, being relatively transparent and up front. This is what the consultation is all about. Dr. Gulati was also aware of the way in which she was affected by appearances and, as a doctor, was able to counteract this. But in the background to their encounter, there is a wide range of other values, to a greater or lesser extent deeply hidden, and yet no less important to how the consultation goes.

Among background values we have already noted are, for example, the influences on Dr. Gulati and Roy Walker of their respective social groups, the strong commitment among a majority of Dr. Gulati's colleagues to the cost-effective use of resources, and the very different but equally powerful peer pressures on Roy Walker arising from local cultural models of maleness.

There are many other background values in play. Dr. Gulati's professional values, for example, gave her a strong sense of loyalty to her colleagues, including Dr. Austin who, although now causing problems by being rather too ready to issue off-work certificates, had originally encouraged Dr. Gulati to join the practice and had supported her strongly in her early years as a GP. Then again, there were also the interests of Roy Walker's family to consider. Dr. Gulati, as we noted, was concerned that Roy Walker might take out his frustration on his wife and children if she refused to give him "his usual."

The network of values

Background values, furthermore, are very far from being confined to the values of those directly concerned in a given clinical encounter. Indeed, once you start thinking along these lines, it becomes clear that there is a whole web of people and institutions whose values, foreground and background, will critically influence how the consultation between Dr. Gulati and Roy Walker goes. Relevant values include:

- The values (needs, wishes, expectations, etc.) of the wider community, including in this instance Dr. Gulati's cultural group.
- The commercial imperatives of Roy Walker's employers and the job center's targets.
- The policy priorities of each of the many UK National Health Service (NHS) organizations within which general practice is embedded and those of central government.
- The standards embedded in the codes and guidelines of the General Medical Council (GMC; the regulatory authority for doctors in the UK) and other professional organizations.
- The targets set by the Care Quality Commission and the many other groups with responsibility for monitoring standards in the NHS.

Still other important components of the network of values are all the policy priorities and other values that go into shaping both the primary research and the derived evidence-based guidelines that underpin clinical practice and on which, therefore, Dr. Gulati is directly or indirectly relying.

Key point 2: values everywhere

Values then, to come to our second key point, *are everywhere in medicine*. Like the air we breathe, they are not always noticed for what they are (many are in the background rather than the foreground). But also like the air we breathe, whether they are noticed or not, values are always important.

Values-based practice is in part about making explicit the range and variety of values bearing on the clinical consultation and managing them more effectively. We will be exploring the values network within which the consultation between Dr. Gulati and Roy Walker was embedded further at several points in this and the next chapter and also when we return to their story in Chapter 14. But first it will be worth stepping back for a moment to think about what exactly all these different kinds of values have in common. This will take

us to our third key point, namely that values in all their range and variety of forms are all action-guiding.

Values are action-guiding

Thus far, and drawing only on a brief snapshot of the initial encounter between Dr. Gulati and Roy Walker, we have seen that values are:

- *wider than just ethics*, extending to needs, wishes, preferences and so forth;
- *everywhere*, including the values of *clinician as well as patient*, extending to *background as well as more obvious foreground values*, and all set within an extensive *network of values*.

But if values cover such a remarkably wide terrain, what exactly *are* values? What is the common factor? What is it that makes all these very different things *values*? And exactly how does such a diversity of values *bear on clinical decision-making*?

What then *are* values?

"Values" is one of those words that everyone uses assuming they know what it means but which turns out on reflection to be remarkably difficult to define. The word "values" is not alone in this. In evidence-based medicine, for example, there is much discussion of "best evidence" but what exactly the word "evidence" means is left largely unquestioned.

Nonetheless, various definitions of "values" have been suggested by, among others, some of the path-finders for *evidence*-based medicine. David Sackett and his colleagues, for example, in their foundational book on evidence-based medicine (to which we referred earlier) put it this way:

> By patient values we mean the unique preferences, concerns and expectations each patient brings to the clinical encounter and which must be integrated [with best research evidence and clinical experience] into clinical decisions if they are to serve the patient.
>
> Sackett *et al*. (2000, p. 1)

This is a helpful definition in many ways. True, Sackett's definition focuses only on patients' values, and, as we have already seen, Dr. Gulati's values are as material as those of Roy Walker to values-based decision-making, while the relevant network of values extends well beyond those of the clinician and patient directly involved. Nonetheless, Sackett's definition:

- reminds us that values in medicine are wider than ethics: values in Sackett's definition include "preferences, concerns and expectations";
- explicitly links values, both positive ("preferences") and negative ("concerns"), with evidence in clinical decision-making: values, he says, have to be *integrated* with evidence and clinical experience in clinical decision-making;
- makes clear the importance of values in, as we put it in the subtitle to this book, linking science (represented by generalizable evidence) with people (as unique individuals each with what might be called their own "values fingerprint"). In Sackett's words values are "the *unique* preferences, concerns and expectations *each patient* brings to the clinical encounter."

Helpful as it is, however, Sackett's explanation of the meaning attached to values in their book falls short of actually nailing what exactly values *are* and hence exactly *why* values (in all their remarkable range and diversity) are relevant to clinical decision-making.

Values, decisions and actions

For a deeper understanding of values and their relevance to clinical decision-making, we turn to the work of an Oxford philosopher, R. M. Hare. As a former White's Professor of Moral Philosophy in Oxford, Hare worked in what is sometimes called "ordinary language" philosophy. This mid-twentieth-century school of analytic philosophy explored the meanings of complex concepts like "values" by looking carefully at how the concepts in question are actually *used* in everyday (i.e. ordinary) contexts.

With its down-to-earth and somewhat empirical approach, ordinary language philosophy has many resonances with medicine – one of its practitioners called it "philosophical field work" (Austin, 1956–1957, p. 25). Values-based practice is essentially a practical spin-off from the work of the Oxford School (see Fulford, 1989 and the series website) and remains an area of ongoing study. Hare's work, however, takes us straight to the bottom line for clinical decision-making, for what Hare showed was that the many and diverse varieties of values are all *action-guiding* – "prescriptive" is the term he used (Hare, 1952).

Key point 3: values are action-guiding

That values are all action-guiding is the third of our three key points about values in medicine. The implications for clinical decision-making are clear – actions

in a clinical context are guided not only by evidence *but also by values*. Clinical decisions thus stand on two feet. They are guided by evidence and by values. The evidence footing is broadly construed as including both research evidence and the evidence of clinical experience. The elements of the values footing will become clearer as we move on.

It will be worth considering this point about the two feet of decision-making (the need for a values foot as well as an evidence foot) in a little more detail as it plays out in different kinds of clinical situation.

Clinical decision-making

Values guide clinical decision-making

In this book, we use the term "values," following Hare, to include anything positively or negatively weighted as a guide to healthcare decision-making. This action-guiding sense of the term is clearly evident in the scenario between Dr. Gulati and Roy Walker. Her dilemma was the product of a tension between different values that were "guiding" her in different directions about what to do. The values of patient autonomy and of best interests, for example, were in tension in this respect. There was a similar if more deeply hidden tension arising from Roy Walker's appearance between Dr. Gulati's professional values of objectivity and her cultural and personal aesthetic values.

Roy Walker, too, was "values-guided" – by his fears about his back, his concerns for the future, his self-image as a well-muscled man and so forth. So his values have to be factored into the weightings that will guide the clinical decisions Dr. Gulati has to make. The doctor and the patient, although the central protagonists in this clinical situation, are but part of a wider network of people and institutions whose values – positive and negative – are in different ways critical to how things work out between them.

Evidence also guides clinical decision-making

In her clinical decision-making, Dr. Gulati was also guided by the evidence represented by her clinical experience and relevant research. She was accustomed to using the terms "red flags" and "yellow flags" in her assessment of back disorders. The former alerted her to look out for potentially serious disease like cauda equina compression, while the latter term was based on work by Kendall and Burton in 1997 on the psycho-social factors predicting chronicity and poor outcomes with low back pain (Kendall *et al.*, 2009). These yellow flags are summarized in Table 1.1. As you can see, Roy Walker had a full house. Was his back pain already chronic, or was there a last window of opportunity to affect this?

Evidence that Dr. Gulati relied on quite heavily in her practice was that emanating from the influential UK National Institute for Health and Clinical Excellence, commonly known as NICE guidance. Although reducing work-loss is not part of the NICE brief, yellow flags (as further developed by others, e.g. Corbett *et al.*, 2009) are mentioned in NICE guidance (NICE, 2009). The therapeutic guidance at this point would be that Roy should be referred for an intensive rehabilitation program.

Values as well as evidence in *all* clinical decisions

We chose to present the scenario between Roy Walker and Dr. Gulati as our opening narrative precisely because it is on the one hand so richly values-laden and on the other so strongly evidence-based. But Hare's point was that *all* decisions, clinical or otherwise, and whether overtly value-laden or not, are values- as well as evidence-driven.

Table 1.1. Psycho-social yellow flags for chronic low back pain

A negative attitude that back pain is harmful or potentially severely disabling
Fear avoidance behavior and reduced activity levels
An expectation that passive, rather than active, treatment will be beneficial
A tendency to depression, low morale and social withdrawal
Social or financial problems

From Samanta *et al.* (2003).

Reflection point

At this point you may want to try thinking for a moment about the last clinical decision you made – not the last *difficult* decision, mind, and certainly not the last *ethically* difficult decision.

Think rather about the *last* clinical decision you made, however apparently uncomplicated.

- What evidence underpinned your decision?
- What values underpinned your decision?

Generally speaking, we do not have to reflect too hard on why we take the decisions we do in everyday practice. Just "getting on with the job" working mostly on automatic is integral to what it means to be a skilled professional.

It can often be quite difficult to reconstruct our decisions. When we *do* reflect on any particular decision we have taken, we can generally come up with the evidence base on which we acted – not necessarily the detailed research evidence but at least the broad area of medical knowledge that, together with our individual clinical experience, informs the decision in question. This was the case with Dr. Gulati.

What is perhaps not always so self-evident, even on reflection, is the *values* base of our decisions. In Dr. Gulati's situation, the importance of the weightings provided by values is clear. Her knowledge of the factors associated with poor outcomes with low back pain was, on its own, not sufficient to drive her clinical decisions. Her view that she ought not to issue an off-work certificate was the result of *combining* (or "integrating" as Sackett *et al.*, 2000, put it) this evidence-based knowledge with her values-based commitment to acting in her patient's best interests. And her *dilemma* about what to do in this instance consisted, as we noted a moment ago, precisely in the fact that *other* values (such as patient autonomy) ran directly counter to the importance she placed on "best interests."

Values and prescribing an antibiotic

Hare's point is that *all* decisions, even those that are not overtly value-laden like Dr. Gulati's, depend not only on evidence but also on the positive and negative weightings provided by values. If you tried reflecting on your own last decision, as in the reflection point above, you may well have found this for yourself. Suppose, for example, that your decision was about prescribing an antibiotic for, say, pneumococcal pneumonia. Your choice of antibiotic will clearly have been evidence-based. It is likely to have been guided by your local formulary, which combines evidence on local resistance patterns, for instance, with the cost of the different options.

The role of values, on the other hand, is initially less obvious in a case like this. When you think about your antibiotic-prescribing decision further, however, it becomes clear that a whole series of background values have to be connected up with the relevant evidence base – the balance of benefits (antimicrobial efficacy) and harms (side effects), the cost-effectiveness of the antibiotic in question ("cost" and "effectiveness" both being value-laden concepts), wider economic issues around health budgets, and so on. Indeed, a decision as apparently un-value-laden as prescribing an antibiotic turns out, on reflection, to be embedded in much the same network of values as Dr. Gulati's overtly value-laden dilemma about issuing an off-work certificate.

Chapter summary

Drawing on the opening clinical encounter between Dr. Gulati and Roy Walker, this chapter has illustrated three key points about values in medicine:

1. Values are *wider than ethics* – they extend to needs, wishes, preferences and so forth.
2. Values are *everywhere* – they include the values of clinician and patient, both foreground and background values, and the wider network of values.
3. Values are *action-guiding* – they include anything positively or negatively weighted as a guide to clinical decision-making.

In the next chapter, we follow Dr. Gulati as she turns first to codes of practice and ethics and then to evidence-based practice and decision analysis in trying to decide how to respond to Roy Walker's demands for an off-work certificate. We will find that, although all these are indeed helpful up to a point, when applied to particular individual decisions they raise complex values issues. Neither codes of practice nor ethics guidelines, and neither the tools of evidence-based practice nor those of decision analysis, can resolve these complex issues. Thus, at the point of individual clinical decision-making, there is a clear need for values-based practice.

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Websites

- For more on psycho-social yellow flags for chronicity with low back pain see: http://www.kendallburton.com/Flags/flagsindetail.html.
- NICE guidance on chronic low back pain is available as a pdf from: http://www.nice.org.uk/CG88.