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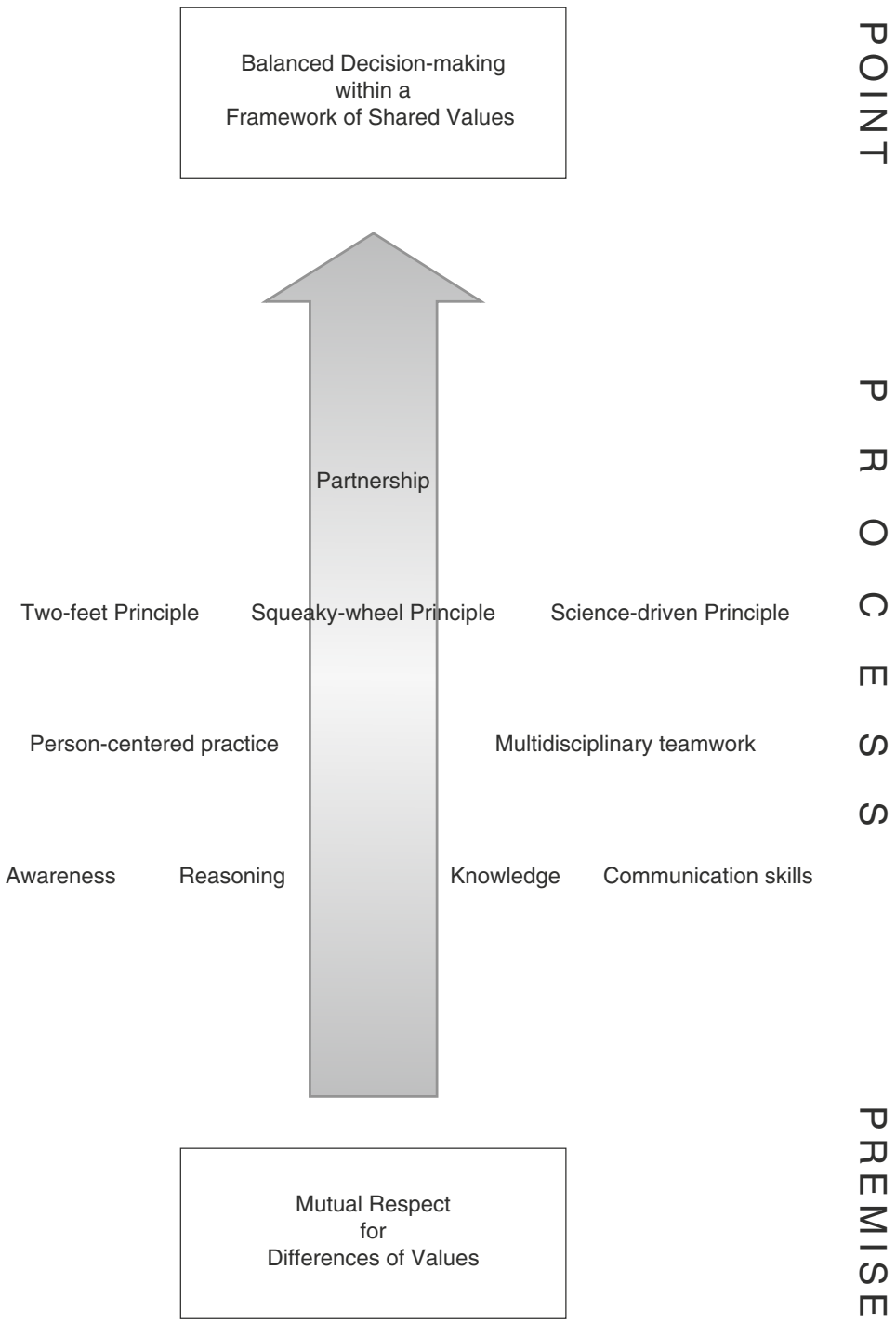

Figure 1.1 Map of values-based practice.

Section 1 VBP: values, practice and philosophy

Chapter 1

Values-based practice: the facts

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Values-based practice is a new skills-based approach to health care decision-making where complex and conflicting values are in play. The flow diagram in Figure 1.1 shows how, starting from a premise of mutual respect, the ten key elements of values-based practice come together to support balanced decision-making within frameworks of shared values.

Values-based practice is only one tool among others in medicine's tool kit for working with values. Besides ethics and law, such tools include decision analysis (Hunink *et al.*, 2001) and health economics (Brown *et al.*, 2005). Values-based practice, in building primarily on learnable clinical skills, adds to the tool kit a particular focus on and ways of working with the diversity of *individual* values.

In this chapter I outline briefly the skills for values-based practice, the nature of professional relationships within values-based practice, the links between values-based and evidence-based practice, and the concept of dissensus at the heart of partnership in values-based decision-making. I then turn to theory: values-based practice as I will show owes many of its defining characteristics to its origins in a branch of analytic philosophy called ordinary language philosophy applied to the language of values. In a brief concluding section I indicate the importance of values-based practice for medicine as a science at the cutting edge.

The skills for values-based practice

Crucial to the practical effectiveness of values-based practice has been the development of training materials for frontline staff. The first training manual, appropriately titled *Whose*

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Values? (Woodbridge and Fulford, 2004), was launched by the then Minister of State with responsibility for mental health, Rosie Winterton, at a conference in London in 2005. *Whose Values?* was the basis for a series of national policy, training and service developments in the UK and there were similar initiatives in a number of other countries (Fulford *et al.*, 2004).

The starting point for training in values-based practice is raised awareness of values and it is on this that I focus here, although with a few comments also on reasoning, knowledge and communication skills (see Table 1.1 and Figure 1.1). In everyday practice, values-based decision-making depends on a well joined up and unselfconscious use of the skills (and indeed other elements) of values-based practice working together as a whole. Raised awareness however is always the starting point.

Training in awareness of values has two main learning outcomes: an understanding of the diversity of values (including but extending well beyond ethical values); and the often surprising nature of the values people actually hold (this includes our own values as well as those of others).

Diversity of values

A word association exercise is a good way to get started. Table 1.2 shows one set of responses to an exercise of this kind with a group of trainee psychiatrists. The group had been asked to 'write down three words or short phrases that mean "values" to you'. As Table 1.2 indicates, everyone produced a different triplet of words! In feedback and discussion the list of associations the group had produced together helped them to see just what a wide and diverse range of things are covered by values – ethical values, certainly, but also needs, wishes, preferences, and indeed anything positively or negatively weighted as a guide to action (Fulford *et al.*, 2012, Chapter 1).

The diversity of values notwithstanding, many values are shared. In this exercise trainees will usually spot this for themselves. Thus in Table 1.2, the values of 'autonomy' and 'best interests' both come up more than once. Recognising such shared values then leads naturally into talking about the relationship between ethics and values-based practice. For shared values are readily identified as the *ethical* values that in values-based practice together provide a framework for partnership in decision-making (see below). The trick though is to see that these same shared framework ethical values are both individually complex and collectively conflicting – best interests for example means widely different things to different people (it is in this sense a complex value); and best interests is often in conflict with autonomy of patient choice.

One response to the complex and conflicting nature of values is to develop ever more elaborate ethical codes. Values-based practice offers a different response. Values-based practice starts from the idea that, while ethical codes provide a vital framework for practice, the complex and often conflicting nature of the values such codes embody has the consequence that the clinical skills and other elements of values-based practice are required in coming to *balanced decisions in individual cases* (Fulford *et al.*, 2012, Chapter 2 – see below, 'Dissensus and partnership', for an example).

Surprising values

Having 'got' diversity the next step is to 'get' surprise. One way to 'get' surprise is illustrated by Figure 1.3. This is taken from a training workshop with a mental health

Table 1.1 A summary of values-based practice (VBP)

Elements of VBP	Brief explanations
Premise	The basis for balanced decision making in VBP is the premise of **mutual respect for differences of values**
Ten-part process	VBP supports balanced decision making through **good process** rather than prescribing preset right outcomes. The process of VBP includes four areas of **clinical skills**, two aspects of **professional relationships**, three principles **linking VBP with EBP**, and **partnership in decision making** based on 'dissensus'
The four skills areas are	
(1) Awareness	The first and essential skill for VBP is raised awareness of values and of the often surprising diversity of individual values
(2) Reasoning	Values reasoning in VBP may employ any of the methods standardly used in ethics (principles reasoning, case-based reasoning, etc.) but with an emphasis on opening up different perspectives rather than closing down on 'solutions'
(3) Knowledge	A key skill for VBP is knowing how to find and use knowledge of values (including research-based knowledge) while never forgetting that each individual is unique (we are all an 'n of 1')
(4) Communication	VBP communication skills, include skills (1) for eliciting values, in particular StAR values (Strengths, Aspirations and Resources), and (2) for conflict resolution
The two aspects of professional relationships are	
(1) The extended MDT	The role of the MDT (multidisciplinary team) in values-based practice is extended from its traditional range of different professional skills to include also a range of different value perspectives
(2) Patient-values-centered care	In VBP, patient-centered care means focusing primarily on the patient's values though other values (including those of the clinician) are important too
The three principles linking VBP with EBP are	
(1) 'Two feet' principle	The 'two feet' principle of VBP is that all decisions are based on values as well as evidence even where (as in diagnostic decisions) the values in question may be relatively hidden
(2) 'Squeaky wheel' principle	The 'squeaky wheel' principle of VBP is that we tend to notice values when they are conflicting and hence causing difficulties (based on the saying 'it's the squeaky wheel that gets the grease')
(3) 'Science driven' principle	The 'science driven' principle of VBP is that the need for VBP is driven by advances in medical science (this is because such advances open up new choices and with choices go values)
Partnership in decision making	
. . . based on dissensus	Consensual decision making involves agreement on values, with some values being adopted and others not. In dissensual decision making by contrast, different values remain in play to be balanced sometimes one way and sometimes in others according to the particular circumstances of a given case
Outputs	Rather than giving us answers as such, VBP aims to support **balanced decision making within frameworks of shared values** appropriate to the situation in question

Table 1.2 What are values?

Faith Internalisation 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-centred 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

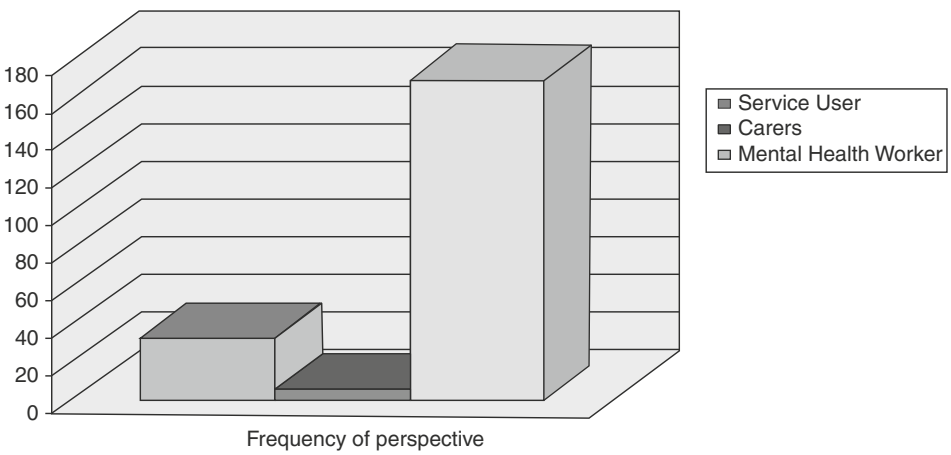

Figure 1.2 The perspectives expressed in a case review meeting.

team in London (Fulford and Woodbridge, 2008). It shows the values implicit in the comments of team members in a case review meeting. The team in question had asked for training in values-based practice because of their shared commitment to a person-centred approach. This was the team's shared core value in fact. Yet as Figure 1.2 shows, the values actually expressed by team members in their meeting (and thus likely-as-not in their practice as well) were very largely their own rather than those of their clients.

This came as a considerable surprise to the team. But precisely *because* it came as such a surprise it proved a strong basis on which to build their training in values-based practice.

Reasoning, knowledge and communication skills

Reasoning, knowledge and communication skills are of course not unique to values-based practice. Values-based practice, however, brings a particular and unique slant to each of them. The result is a two-way relationship in which values-based practice depends (in part) on reasoning, knowledge and communication skills, while, conversely, reasoning, knowledge and communication skills are all in different ways enriched by values-based practice.

Thus, in the case of reasoning skills, values-based practice employs any and all of the established methods of ethical reasoning (such as principles reasoning, casuistry or case-based reasoning, utilitarianism and deontology). It is in this sense that values-based practice depends in part on ethical reasoning skills. Values-based practice in turn, however, enriches ethical reasoning by using it not to derive ethical conclusions as such but rather to explore the 'space of values', i.e. the range of often very diverse values bearing on a given situation (Fulford *et al.*, 2012, Chapter 5).

Knowledge acquisition and values-based practice are in a similar way mutually reinforcing. On the one hand, the skills of knowledge acquisition required for values-based practice are essentially the same as in any other area: they include everything from day-to-day experience through to full-on evidence-based medicine. True, retrieving knowledge of values from electronic databases requires nuanced use of search terms (Petrova *et al.*, 2011). But the skills of knowledge acquisition are essentially the same. On the other hand though, values-based practice brings to knowledge acquisition a unique slant in setting a definite limit on what can be known. In values-based practice, generalised knowledge, however reliable and complete, can never trump the actual values of a given individual in a given situation. In values-based practice then, the individual is always an '*n* of 1' (Fulford *et al.*, 2012, Chapter 6).

This is one reason why communication skills are so essential to values-based practice: if the individual is always an '*n* of 1' then the skills for eliciting values are essential if decision-making is to be based on the actual rather than imagined values in play. Another reason is the sometimes conflicting nature of values (as above) with its consequent requirement for skills of conflict resolution (Fulford *et al.*, 2012, Chapter 7).

Again though, the relationship is two-way. For what matters in practice is not communication skills as such but what they are used to communicate. In the UK, for example, medical students are taught to enquire about ideas, concerns and expectations (ICE). In practice students (and indeed more experienced clinicians) tend to focus only on the negatives. This is natural enough given that patients by definition present with 'problems'. In coming to a balanced view, however, as the basis for an effective management plan it is important to look also at the positives, at the strengths, aspirations and resources of the person concerned (National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership, 2008). Values-based practice then, in adding strengths, aspirations and resources to ICE, gives us ICE-StAR (Fulford *et al.*, 2012, Chapter 7).

Professional relationships in values-based practice

In the past, professional relationships in health care were predominantly doctor centred. Contemporary health care practice is characterised instead by a person-centred approach supported by multidisciplinary teamwork (see e.g. Thistlethwaite, 2012). Both of these approaches, as Figure 1.1 and Table 1.1 indicate, are important in values-based practice though in each case with a particular and distinctive edge, captured in the concepts respectively of 'person-*values*-centred care' and of the '*extended* multidisciplinary team'.

The importance of person-*values*-centred care in values-based practice follows directly from the individuality of values. If each of us is an *n* of 1, then person-centred care is nothing if it is not person-*values*-centred care. Person-centred care has a number of different meanings in modern health care: it includes genetically targeted treatments for example. The distinctive edge that values-based practice brings is to show that whatever else the 'person' in person-centred care means it must include care that is responsive to (though not of course entirely determined by) the values (positive and negative) of the person in question as a unique individual: hence the central significance of the *values* added to 'person-centred-care' in the 'person-*values*-centred care' of values-based practice (Fulford *et al.*, 2012, Chapter 8).

It is to the delivery of person-*values*-centred care that the '*extended* multidisciplinary team' of values-based practice is essential. Multidisciplinary teams bring a variety of distinct areas of knowledge and skills to the complex challenges of modern patient care. Values-based practice extends the importance of the multidisciplinary team to include also the distinct *values* of different team members. It is in this specifically *values* sense that the multidisciplinary team of values-based practice is an '*extended* multidisciplinary team'.

The extent of differences in team values is illustrated by Table 1.3. This is based on research by the British social scientist, Anthony Colombo, in which he explored the values implicit in the work of community-based multidisciplinary mental health teams (Colombo *et al.*, 2003). Asked directly, team members, from whatever professional background, will express a shared commitment to a balanced 'bio-psycho-social' perspective. In Colombo's research, however, the perspectives implicit in team members' actual working practices strongly reflected their respective professional backgrounds. Table 1.3 shows the findings for psychiatrists and social workers: psychiatrists adopted a medical perspective (the 'bio' in the 'bio-psycho-social' model) with almost no overlap at all with the psychosocial perspective of social workers.

Making such implicit differences of perspective explicit is important for communication and shared decision-making. Their full significance, however, only became apparent when Colombo went on to show that patients too showed a *similar range of perspectives* as professionals.

The extent of the similarities between the perspectives of team members and those of patients can be seen by comparing the perspectives of psychiatrists and social workers in Table 1.3 with those of the two groups of patients shown in Table 1.4. As can be seen, patients in this study divided naturally into two groups expressing respectively medical and psychosocial perspectives essentially similar to those of psychiatrists and social workers. Hence the importance of different team values – for a shared *perspective* facilitates shared *understanding*. So the different value perspectives of team members

Table 1.3 Perspectives of psychiatrists (P) and social workers (S) (shared cells highlighted)

Elements	Models – psychiatrists					Political
	Medical (organic)	Social stress	Cognitive behaviour	Psycho-therapeutic	Family (interaction)	
1 Diagnosis/ description	P					
2 Interpretation of behaviour	P					
3 Labels	P					
4 Etiology	P					
5 Treatment	P					
6 Function of the hospital	P	P				P
7 Hospital and community	P					
8 Prognosis	P					
9 Rights of the patient	P					
10 Rights of society	P					
11 Duties of the patient	P		P			
12 Duties of society	P					
Elements	**Models – social workers**					**Political**
	Medical (organic)	**Social stress**	**Cognitive behaviour**	**Psycho-therapeutic**	**Family (interaction)**	
1 Diagnosis/ description				S		
2 Interpretation of behaviour				S		
3 Labels				S		
4 Etiology				S		
5 Treatment		S			S	
6 Function of the hospital	S	S				S
7 Hospital and community		S		S		
8 Prognosis				S		
9 Rights of the patient	S	S				S
10 Rights of society	S					
11 Duties of the patient			S			
12 Duties of society		S				

Table 1.4 Perspectives of two groups of patients

Elements	Models – Group 1 (similar to psychiatrists)					Political
	Medical (organic)	Social stress	Cognitive behaviour	Psycho-therapeutic	Family (interaction)	
1 Diagnosis/ description	**Pt-Med**					
2 Interpretation of behaviour			**Pt-Med**	**Pt-Med**		
3 Labels	**Pt-Med**					
4 Aetiology	**Pt-Med**					
5 Treatment	**Pt-Med**					
6 Function of the hospital	**Pt-Med**	**Pt-Med**				**Pt-Med**
7 Hospital and community		**Pt-Med**		**Pt-Med**		
8 Prognosis	**Pt-Med**					
9 Rights of the patient	**Pt-Med**					**Pt-Med**
10 Rights of society		**Pt-Med**				
11 Duties of the patient		**Pt-Med**	**Pt-Med**			
12 Duties of society	**Pt-Med**		**Pt-Med**			**Pt-Med**
Elements	**Models – Group 2 (similar to social workers)**					**Political**
	Medical (organic)	**Social stress**	**Cognitive behaviour**	**Psycho-therapeutic**	**Family (interaction)**	
1 Diagnosis/ description				**Pt-SW**		
2 Interpretation of behaviour				**Pt-SW**		
3 Labels			**Pt-SW**	**Pt-SW**		
4 Aetiology				**Pt-SW**		
5 Treatment		**Pt-SW**		**Pt-SW**		
6 Function of the hospital	**Pt-SW**					**Pt-SW**
7 Hospital and community		**Pt-SW**		**Pt-SW**		
8 Prognosis				**Pt-SW**		
9 Rights of the patient	**Pt-SW**	**Pt-SW**				**Pt-SW**
10 Rights of society		**Pt-SW**				
11 Duties of the patient		**Pt-SW**	**Pt-SW**			
12 Duties of society			**Pt-SW**			**Pt-SW**