COLLEGE OF paramedics
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Handbook
Values-Based Practice and Paramedic Practice

Education Advisory Committee

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Preface

It's a dreary, autumn weekend when, approaching the end of your shift, you are dispatched to a 111 call, 83-year-old female who has fallen, no injury. The initial call time is some 3 hours before you've been dispatched. Could be a nice little off-job.

On your arrival to a well-kept home, you're met by well-meaning neighbours who had found the patient on the floor. Margaret appears well, and the initial primary assessment finds no abnormalities, and you help her to her feet and through to her living room where you continue your assessment.

Margaret has congestive cardiac failure and chronic kidney failure, meaning she often has oedema to her ankles, legs and limbs and sometimes she finds it difficult to walk. Due to a lack of engagement with her GP, inconsistency in taking her prescribed medication, and increasing problems carrying out activities of daily living, you think that Margaret would benefit from a review in the local ambulatory care unit. The neighbours confide that Margaret has little family, and a handful of friends from church, and they are worried she's been neglecting herself.

A familiar nod to your crewmate, and the carry chair and blanket appears. As you outline that you will be taking Margaret to hospital, she looks at you, horrified; "No, I won't go. I won't ever come out if you take me in."

You look at your crewmate, exasperated.

A familiar encounter? Clinical decisions by paramedics are increasingly made against a background of complex, and often conflicting values. The most obvious evidence of this is in the growing importance of ethical issues in healthcare. But there are many other increasingly "values complex" areas of paramedicine, such as clinical governance, audit, quality assurance, and the use of quality-of-life and other similar measures in preventive and public health medicine.

Just as we need a clear evidence-base, because of the increasing complexity of the *evidence* underpinning decision-making, so increasingly do we need values-based practice due to the increasing complexity of the *values* underpinning challenging decision-making.

In 1966, Sackett et al were credited in fathering the definition of evidence-based medicine:

The conscientious explicit and judicious use of the current best evidence in making decisions about the care of individuals and patients. (p. 71)

Some fifty years later, we often continue to overlook the following sentences in that definition, which point to clinicians having a "*more thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences in making clinical decisions about their care*." (ibid). These unique predicaments, rights and preferences which each patient brings to a clinical encounter are their *values.* Evidence-based medicine has evolved and broadened into evidence-based practice, underpinning the work of paramedics and all other allied health professionals, but the underlying principles remain the same. Is it possible that, in our wish to provide the best evidence-based care to our patients, we may have inadvertently overlooked their values?

What are values?

Despite its ubiquity, "of all the widely invoked concepts, few are as difficult to specify as the concept of values" (Almond & Wilson, 1988, p. 1). The origin of values is a contentious subject, and are often wrongly conflated with virtues, morality, and logic: only similar in that they can all be consciously and subconsciously explored by the individual. However, their longevity means that values have come to be defined from a range of perspectives, as being the "standards by which our actions are selected" or as a "belief upon which man acts by preference" (Allport, 1961, p. 454). Both these definitions focus on an action and imply a degree of choice.

Values are also commonly viewed as moral principles, or "guidelines for individual, societal actions and… the regard one person has for another – their integrity, trustworthiness and moral character" (Thomas, Burt, & Parkes, 2010, p. 16). The Oxford English Dictionary defines 'value' to consider of worth or importance; to rate highly; to esteem; to set store by" (2018). This appears to be the most widely accepted definition, where values are associated with some 'good', such as truth, according to Halstead (1996), or as experiences or activities that serve to encourage human well-being (Beck, 1990).

It is this action-guiding feature of values that makes them a fundamental element alongside evidence within all clinical decision making, as Sackett's original definition outlines. However, unlike published evidence, values are not always explicit. In our latest pre-registration / undergraduate paramedic curriculum (Version 5), we have outlined how best students can understand, access and implement best-practice evidence in decision-making. It is now the time that we turn our attention to values.

Values-based Practice as a twin framework to Evidence-based Practice

Evidence-based practice assists clinicians in clinical decision-making by using the best available evidence to ensure decisions made about care are both safe and effective. Evidence-based practice and values-based practice remain inextricably linked, they extend only as far as the individual clinician. This occurs on a case by case basis, and a value in one setting with one patient may not transpose to another. Posited as a twin framework to evidence-based practice, values-based practice offers the healthcare practitioner a mechanism by which to understand the perspectives of the patient by understanding their values, rather than blindly providing care that evidence suggests is beneficial. Both these operate alongside and within the proficiency and judgement individual clinicians acquire through their clinical experience and practice.

Values-based Practice in the Paramedic Undergraduate Curriculum

Whilst the undergraduate curriculum outlines the importance of evidence-based practice, it has, until now, omitted values-based practice. Although it is not a new concept, values-based practice has been gaining much momentum across the healthcare disciplines over the last ten years. There are both opportunities and challenges in bringing values and evidence together in paramedic practice, and the

Education Advisory Committee within the College of Paramedics are keen to ensure both student and qualified paramedics become values-aware.

As values are action guiding, the implication of values on decision-making is widely acknowledged. How students are trained to deal with values - to notice them within themselves, to reflect on their own values and to recognise them within others, and to balance them within the care they deliver, is paramount to an effective health service and ultimately the delivery of patient care. If we can understand it, teach it well, and explicitly embed this in our practice, we truly will be delivering evidence-based medicine.

Introduction

Together with the Collaborating Centre for Values-Based Practice, the Education Advisory Committee of the College of Paramedics has developed this handbook to guide how values-based practice may be taught to undergraduate paramedic students. However, this handbook is not limited to those entering the profession alone, and is useful to those who may have been qualified for some years without understanding the concept, and importance, of values in paramedic practice.

The handbook includes a number of guiding principles and key ideas about values-based practice. We hope the sample materials and training protocols included will prove helpful. Successful implementation of values-based practice depends on development and adaptation of the approach to meet the particular contingencies of a given clinical area and service context. Paramedics work across many different settings, both clinical and non-clinical, yet the ethos of values-based practice is pertinent to them all. Extending values-based practice within paramedic practice will thus be an iterative process. The template set out in this toolkit is a starting point. But the aim is that it should be progressively developed and enriched through **feedback** and contributions from those using it in practice.

Raised awareness of values is essential to contemporary person-centred care. Sustainable implementation however depends on a whole system approach incorporating other elements of values-based practice. This handbook is primarily designed to introduce paramedics to the concept of values-based practice, ensuring our profession (regardless of experience) becomes values-aware. For teaching undergraduate students, this handbook should be read as standing alongside and in partnership with the Curriculum Guidance document.

Aims

Our aim is to highlight the role of values in patient care and make explicit the concept of values-based practice as an important element within evidence-based practice. Our overall aim is to ensure that all paramedics continue to give the best care to each patient.

How this Handbook Works

The Handbook is divided into three main parts:

Part I, **About Values-based Practice** provides a brief introduction to values-based practice focusing on its role in clinical care. Key points about the 'What?', the 'Why?' and the 'How?' of values-based practice are illustrated with examples from emergency and unscheduled care.

Part II, The Training Template presents the resources to teach values-based practice that have been applied consistently within medicine, surgery and radiography. The template consists of the introductory training model which consists of three Seminar Building Blocks.

- Seminar Building Block 1: Interactive exercises introducing values and values-based practice.
    - These exercises are key to developing the skills for values-based practice. This section gives the learning outcomes and points to watch out for in running the exercises and explains how they support training in values-based practice in clinical care.

- Seminar Building Block 2: Discussion of cases from everyday practice

- Seminar Building Block 3: Take home messages for changing practice

Part III, The Resources Library, provides a range of materials to teach seminars in values-based practice as part of the introductory model. These materials have been compiled by the Collaborating Centre for Values-Based Practice and the Education Advisory committee. These include:

- A step-by-step guide to organising and running a seminar in values-based practice
- Example seminar outlines
- Case studies
- Powerpoint presentations

- Supplementary scenarios for non-registered clinicians
- Feedback forms

All these resources are available to download (subject to Accreditation and Shared Learning).

Accreditation to teach Values-Based Practice

As with any area of skills training there is much that it is impossible to convey in a handbook. However detailed the instructions given, without direct transfer of tacit knowledge through shared learning, the risk is that values-based practice will end up becoming yet another mechanical tick-box exercise.

For this reason, we encourage anyone planning to use the Handbook to contact us with a view to joining a training session in values-based practice. Attending one session allows a deeper understanding of what values-based practice is all about and this in turn gives a firmer foundation on which to develop and adapt the handbook template to meet the particular contingencies of your own area of practice and education. In this way, values-based practice remains an open and outward-looking discipline growing through shared learning across an increasingly diverse community of clinical care. The resources described above are available only after attending a training session.

With continuing support from the Collaborating Centre for Values-Based Practice, we have also set up a group to bring all paramedics who are interested in developing how values and values-based practice is taught within the curriculum. More information can be found here: https://valuesbasedpractice.org/what-do-we-do/networks/**values-based-practice-in-paramedic-practice**/\

Part I – About Values Based Practice

Overview

The section provides a brief introduction to values-based practice. Illustrated with clinical examples from emergency and unscheduled care, the section covers the following key points:

1. What are values?
2. What is Values-based Practice?
3. Why is Values-based Practice Important Clinically?
4. How is Values-based Practice Implemented?

1. What are values?

Values are at the heart of values-based practice, and some attention needs to be given to what is meant by this widely used term.

Values has many meanings – this is why training in values-based practice usually starts with one or more simple exercises exploring its diversity of meanings within even a small group of (mainly) like-minded participants. Unfortunately, "of all the widely invoked concepts, few are as difficult to specify as the concept of values" (Almond & Wilson, 1988, p. 1), which makes an introductory text to the subject difficult to write! The origin of values is a contentious subject, and are often wrongly conflated with virtues, morality, and logic: only similar in that they can all be consciously and subconsciously explored by the individual. However, their longevity means that values have come to be defined from a range of perspectives, as being the "standards by which our actions are selected" or as a "belief upon which man acts by preference" (Allport, 1961, p. 454). Both of these definitions focus on an action and imply a degree of choice.

Values are also commonly viewed as moral principles, or "guidelines for individual, societal actions and… the regard one person has for another – their integrity, trustworthiness and moral character" (Thomas, Burt, & Parkes, 2010, p. 16). The Oxford English Dictionary defines 'value' to 'consider of worth or importance; to rate highly; to esteem; to set store by" (2018). This appears to be the most widely accepted

definition, where values are associated with some 'good', such as truth, according to Halstead (1996), or as experiences or activities that serve to encourage human well-being (Beck, 1990).

In values-based practice the term 'values' means **what is important or matters to the particular individual or group** involved in a given situation. This definition covers many of the commoner specific meanings of the term – it includes for example ethical values; also the 'predicaments, rights and preferences' highlighted by David Sackett – but it is not limited to these. So, the definition is helpful in being very inclusive. This is important as it corresponds with the inclusiveness of values-based practice.

The definition is also helpful in acknowledging the centrality in values-based practice of attending to what is important for a particular individual or group. Sometimes the term 'values-based' is used to mean basing policy or practice on a given set of values and encouraging (or even enforcing!) compliance. Values-based practice in the form presented in this manual is about starting from and working with the diversity of individual values as these come into clinical decision making.

This is why as we will see later values-based practice is a partner to evidence-based practice. Evidence-based practice provides generalised evidence about what works for a given type of healthcare problem. Values-based practice helps us as paramedics to link this generalised evidence with the values of (with matters or is important to) the particular individual presenting with the problem in question. It is this action-guiding feature of values that defines values-based practice. We give many examples of this later in the handbook.

2. What is values-based practice?

In 1966, Sackett et al were credited in fathering the definition of evidence-based medicine:

> *The conscientious explicit and judicious use of the current best evidence in making decisions about the care of individuals and patients.* (p. 71)

Some fifty years later, we often continue to overlook the following sentences in that definition, which point to clinicians having a "*more thoughtful identification and compassionate use of individual patients' predicaments, rights and preferences in making clinical decisions about their care*." (ibid). These unique predicaments, rights and preferences, each patient brings to a clinical encounter are their *values.* Therefore, values are as fundamental an element alongside evidence within all clinical decision making, as Sackett's original definition outlines. However, unlike published evidence, values are not always explicit. This is later made explicit in the first training manual in evidence-based practice, where Sackett (2001) outlines that "*bringing together best evidence, with clinical experience and patient* values" must be integrated into clinical practice to best serve the patient.

Values-based practice is a sister framework to evidence-based practice. Based on learnable clinical skills, values-based practice supports health care professionals in shared evidence-based decision-making with their patients based on dialogue about values.

Evidence-based practice assists clinicians in clinical decision-making by using the best available evidence to ensure decisions made about care are both safe and effective. Today, evidence-based practice is often culminated in guidelines, such as those produced by the National Institute for Health and Care Excellent (NICE). However, evidence-based practice and values-based practice remain inextricably linked, though they extend only as far as the individual. Posited as a twin framework to evidence-based practice, values-based practice offers the paramedic a mechanism by which to understand the perspectives of the patient by understanding their values, rather than blindly providing care that evidence suggests is beneficial. Both of these operate alongside and within the proficiency and judgement individual clinicians acquire through their clinical experience and practice.

In giving clinicians the skills to work with values as well as evidence values-based practice links science with people.

3. Why is values-based practice important clinically?

Returning to Margaret as our example.

Margaret had a fall at home. When she didn't attend the Church in the morning, her fellow parishioners went to her house and found Margaret on the floor in the living room. They dutifully called for an ambulance, and two paramedics arrived.
Margaret hadn't any injuries and so she was assisted to the sofa, where the paramedics continued to assess her. Margaret has congestive cardiac failure and chronic kidney failure, meaning she often has oedema to her ankles, legs and limbs which means she sometimes finds it difficult to walk. Due to a relative lack of engagement with her GP and inconsistency in taking her prescribed medication, the paramedics think that Margaret would benefit from a review in hospital. The paramedics were also concerned about the lack of social support Margaret had: her relative lack of engagement with her GP and self-distancing from family meant that she had been neglecting herself. The paramedics bought in the carry chair and blanket, preparing to take Margaret to hospital.
Margaret refuses to attend hospital saying, "I won't ever come out if you take me in". The paramedic asked her to tell them more about that, and Margaret explained how her husband had had a simple fall, had been admitted to hospital for a "full work up" and had subsequently died of pneumonia 12 weeks later. Margaret's family had been pushing for her to go into the local residential home, but Margaret had resisted it – wishing to remain in her own home for as long as possible.

Asking Margaret to explain why she was resistant to going to hospital emphasises a recognition on the part of the paramedics that there is something else going on and they should take time to explore it. This is more than what is written in a clinical guideline, and at this point the paramedic is opening up the opportunity to integrate values within evidence in order to best care for Margaret.

The paramedics explained that what Margaret needed was a medical review as she had not had one for some time. Margaret had been so scared that engaging with her GP would lead to an admission, that she had ignored their requests for appointments and had subsequently deteriorated. After a brief discussion, Margaret consented for the paramedic to phone her GP to see what they could arrange in her own home. They were able to book a domestic phlebotomy appointment, a home visit from the community social prescriber, and a telephone consultation with her GP.

Most older adults who fall are scared about the situation that caused them to fall. It is natural therefore that the paramedics should assume this is what mattered to Margaret. No doubt it did matter, but what mattered more to her was to have a level of independence in her own home. It was thus Margaret's *individual values* (what mattered most to her) that determined her shared decision making with the paramedics.

Margaret's story illustrates a number of key points about how values-based practice works clinically:

I. Awareness of values is the essential first step

There are ten theoretical process elements of values-based practice, which will be discussed in ***Part II***. However, as in Margaret's story, the first element of raised awareness of values is the key. The training described in this handbook always start with raising awareness.

II. Values and evidence

Margaret's story, although focusing on values, also reminds us that clinical decision-making should always be evidence- as well as values-based. In Margaret's case, the paramedics had followed what was considered best practice within the UK Clinical Practice Guidelines in looking to have Margaret reviewed in hospital. In discussing her preferences, the Paramedics changed their approach to care. The decision for Margaret to receive care at home demonstrated the knowledge of the advantages and disadvantages of the evidence-based options available (as those outlined within the NICE Clinical Guidance (CG161) Falls in older people: assessing risk and prevention) with what mattered to Margaret (her individual values).

III. Not the only 'value' in the tool box

In practice, many other values besides those of the patient have an impact on clinical outcome. Values-based practice brings the values of the clinician to the fore as well. In addition, the options available to treat Margaret (such as transfer to

hospital, referral to community teams or even doing nothing) reflect health economic values, which in turn reflect political and social values.

This is why values-based practice is best understood as exploring all values relevant to making a decision in that particular place, at that particular time.

Margaret's story is set within a more urgent, unscheduled, setting. However, values are still at play during the emergency element of the paramedic role. Considering the "rights and preferences*" (Sackett et al 1966, p.71)* of patients who are in cardiac arrest or face critical illness or injury is just as important as those encounters which are less time-critical. In these situations, it may be the patient's relatives or friends with whom dialogue is had, and whilst one cannot assume the patient's values, consideration of the values at play is an important consideration in any clinical situation.

IV. Professional Codes of Practice

The importance of connecting evidence with values is emphasised similarly in professional codes and guidelines. The HCPC (Health and Care Professions Council) includes a number of statements to this effect in its guidance, and this includes acting "*in the best interests of the service users".*

V. Shared decision making

The importance of shared decision-making based on values has been spelled out in both evidence-based guidelines and in codes of practice.

In their seminal textbook on evidence-based medicine, Sackett and his colleagues defined evidence-based medicine as combining best research evidence with clinical experience and patients' values in '*a diagnostic and therapeutic alliance which optimises clinical outcomes and quality of life'* (2000: p.1). This has continued throughout all subsequent editions and similar texts. Sackett's emphasis on combining evidence with values is reflected in contemporary evidence-based guidelines. In the UK all NICE guidance emphasises that treatment and care should take into account patients' individual needs, preferences and values.

VI. Consent

The importance of patients' individual values in shared decision-making has been marked by a recent UK Supreme Court decision on consent, the (2015) 'Montgomery judgment'

***Montgomery v Lanarkshire Health Board* (2015)**

Nadine Montgomery was a diabetic woman of small stature. She delivered her son vaginally, but he unfortunately experienced complications owing to shoulder dystocia, resulting in hypoxic insult which resulted in cerebral palsy. Montgomery's obstetrician had not disclosed the increased risk of this complication in vaginal delivery, despite her specifically asking if the baby's size could present a potential problem. Montgomery sued for negligence, arguing that if she had known of the increased risk, she would have requested a caesarean section instead of opting for a vaginal delivery.
The UK Supreme Court judged in her favour in March 2015. This ruling overturned the previous decision made by the House of Lords in the case of *Bolam*, which had been law since the mid-1950s. It established that, rather than being a matter for clinical judgement to be assessed by professional medical opinion, a patient should be told whatever they want to know, not what the doctor thinks they should be told (Chan et al. 2017).

From this case, Montgomery consent has come to mean that clinicians should engage in 'dialogue' with their patient to the point that they have sufficient understanding of the risks and benefits of the options available to make a choice that takes into account their 'own values'

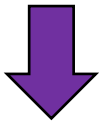
Professional guidance promoting best practice would always seek to involve the patient in their care decisions, so any overt changes to practice are not likely to be seen. Indeed, the ruling in *Montgomery* was seen by a number of commentators to simply recognise the professional guidance regarding consent which had already been in place for a number of years (Chan et al. 2017) and underpin this within case law (Clarke, 2018). Exactly how the Montgomery judgment will be interpreted in different contexts, such as paramedic practice, remains to be seen. But the bottom line is that 'Montgomery consent' is based on *patients' individual values being taken into account* in shared clinical decision-making.

4. How is values-based practice implemented?

Shared decision-making based on dialogue about values is important clinically because it improves patient outcomes and offers an effective way of providing evidence-based care.

The story of Margaret makes this point. Some people in Margaret's situation would have expected transfer to hospital. However, what mattered most to Margaret was staying at home. The whole case was founded on a premise of a mutual respect, and that is the basis of how values-based practice may be implemented. The paramedic had the skills to pick this up and explore its implications with Margaret. But how do we make this kind of shared decision-making routine without it becoming a meaningless tick-box exercise? This is one of those questions to which there is no one right answer. The context of practice as well as our skills and orientation as individual practitioners are important in how values-based practice is implemented. But we can share learning and experience of 'what works'

The remaining elements of values-based practice are summarised in the diagram below. Four key clinical skills ensure the conversations around values and evidence can occur; two elements within the model of service delivery support the use of values and evidence in practice; combined with the strong links that support values and evidence together to make clinical decisions; and partnership in decision making- with the patient, other healthcare professionals as well as relatives and carers. This supports decisions in individual cases within a framework of shared values.

Premise - Mutual respect for differences of values	
	
Key Process Elements	**Outputs**

• Clinical skills:
  • Awareness
  • Reasoning
  • Knowledge
  • Communication
• Aspects of the model of service delivery:
  • Person-centred care
  • Multi-disciplinary team approach
• Strong links between VBP and EBP
• Partnership in decision-making
	These process elements support:
	
	~balanced decision making on
	~individual cases within
	~frameworks of shared values

Again, every situation is different. There is no 'one size fits all' in values-based practice. But like other clinical skills we can learn from others and improve with practice. This is where Part II and the training template comes in.

Part II – The Training Template

This section describes training in the foundational clinical skill for values-based practice, raised awareness of values, and illustrates its applications respectively within clinical teams, with paramedic students, with professional graduates as well as leaders and managers.

Whilst there may be flexibility in its construct, The Collaborating Centre for Values-Based Practice recommends that there are three generic building blocks on which training in raised awareness of values should build:

1. **Interactive exercises** introducing values and values-based practice
2. **Discussion of cases** from everyday practice
3. **Take home messages** for changing practice

The Introductory Training Model		
Seminar	**Content**	**Learning Outcomes**
Building Block One **(1 hour)**	**Brief Introduction To VBP** Two brief (10 minute) interactive group exercises plus plenary discussion	**Raised awareness of:** 1. The many meanings of 'values' 2.Diversity of individual values 3.How this diversity drives different choices from the same evidence-base
Building Block Two **(2 hours)**	**Extended Case Discussion** Small group work plus plenary discussion around everyday case scenarios	Embedding the above and **applying to decision making in everyday practice**
Building Block Three **(1 ½ hours)**	**Application to Practice** Reflection in pairs on personal practice plus plenary feedback: aim is for each participant to come up with one small change they can make to their own practice	Further embedding the above by applying to decision making **in each participants' own** everyday practice

Environment

Values-based practice is nothing if it is not fully integrated into everyday practice. Where possible training should take place in or near participants' everyday working environment as part of their 'day job'.

- For clinical teams, 2-hour multidisciplinary team seminars jointly with patients have been demonstrated to be beneficial.
- Students should receive a similar program within their university, which may be interprofessional or involve users and carers.
- Post-registration seminars could take place off-site but be integrated into their Continuing Professional Development (CPD)

Timing

The aim throughout should be to keep things flowing, however the timings for each seminar building block are examples only.

In a two-hour seminar, 30 minutes should be allocated to the introductory session where participants outline what they consider as values. Once participants start thinking about values they naturally come up with points they want to raise, theoretical and personal. But it is important to keep on schedule to allow sufficient time for the case discussions and ideas about practical implementation in the rest of the seminar.

Seminar Building Block One - Brief introduction to VBP

Training in raised awareness of values has three specific learning objectives

1. To raise awareness of the **range of values** important in healthcare (including needs, preferences, etc as well as ethical values)
2. To raise awareness of the **diversity of individual values** (and that we are very poor at second guessing what matters or is important to other people, i.e. other peoples' values)
3. To raise awareness of how **different values,** drive **different choices** (even with the same evidence base)

Although relatively brief, this warm up session is essential preparation for the case discussions and ideas about changing practice that follow.

'Values' is one of those words in everyday use that has a far richer and more complex set of meanings than we generally recognise. In this respect values are like the air we breathe – all around us, and essential, but largely taken for granted. Hence the exercises in this first session set the scene by getting participants to understand just why values present a challenge for clinical care and hence why we need values-based as well as evidence-based practice.

Rather than a discursive presentation the use of interactive exercises allows participants to recognize this for themselves.

1) The 'three words' exercise

Key message: the surprising diversity of values is why we need values-based practice

The key learning objectives from the 'three words exercise' are to raise awareness of:

1) The wide **range of values** important in healthcare
2) The **diversity of individual** values

These objectives will start to become apparent to participants as they compare notes on their respective three words: they are very likely to have come up with different triplets. The learning objectives are then reinforced by the variety of triplets with which participants as a whole come up in plenary feedback.

In this exercise participants are asked to write down 'three words that mean values to you'. They then discuss briefly in pairs before everyone feeds back their words in a shared plenary with the presenter writing the words up on a flip chart or white board.

FIRST EXERCISE -**What are values?**

1. Write down three words or very short phrases that mean 'values' to you .....

2. Then compare with your neighbour .....

Although there will be some overlaps, everyone is surprised to find they have come up with different words.

1) The **range of values** is reflected in the widely different of words included: 'needs' and 'preferences' for example as well as ethical values such as 'respect' and 'honesty'.
2) The **diversity of individual values** is reflected in the fact that although there are some overlaps (two people include 'respect' for example) every triplet of words is different: most people are really surprised to find that what 'values' means to them is different from what it means to almost everyone else in the room.

Building on this the presenter gives a brief introduction to values-based practice as a resource for working with diversity of values in healthcare.

Points to watch in starting the exercises

There are three main points to watch out for in getting both exercises started

Don't just think - write!

Make sure participants actually write down their answers. The temptation is to just think about them but the exercises have far more impact if participants 'make it real' by committing themselves on paper or their computer.

A good way to reinforce this when you start the first exercise is by indicating that 'for this exercise you will need something to write with' – and then quickly checking to see if everyone has! The resulting scramble for pen and paper or computer and sharing resources, has the further benefit of livening up the session at this early stage!

The order is important

The effectiveness of the exercises depends on participants finding out for themselves that everyone comes up with different answers. So it is worth emphasizing that participants should write down their own answers before comparing notes to see what others have written.

It is helpful to walk round after setting each exercise to see how things are going. Some participants will find these exercises difficult. But encourage them to persist. If they start by discussing with their neighbour rather than having a go for themselves they inevitably pool their ideas and the impact of coming up with different answers is lost.

No right or wrong answers

A common problem when participants are struggling is that they feel there must be a correct answer and they want to 'get it right'. With the 'three words' exercise, explaining that this is simply about word associations for which there are no right or wrong answers, usually works to reassure participants: '… try just writing down the first three words that pop into your head.'

B) A 'forced choice' exercise

Key message: different values drive different clinical choices

The 'forced choice exercise' now reinforces the points about range and diversity of values from the 'three words' exercise and adds two further key learning objectives:

- A shared understanding of values as 'what matters' or 'is important' to people.
- Understanding that diverse individual values drive diverse individual choices (even with the same evidence base).

SECOND EXERCISE - **It's your decision ...**

Imagine you have developed early symptoms of a potentially fatal disease...
NICE has approved two possible treatments
Treatment A - gives you a guaranteed period of remission but no cure
Treatment B - gives you a 50:50 chance of 'kill or cure'

*Given the choice (**Treatment A** or **Treatment B**), how long a period of remission would you want from **Treatment A** to choose that treatment?*

It's your decision ....

"How long a period of remission would I want from Treatment A to choose that treatment rather than go for 50:50 'kill or cure' from Treatment B?

- Write down your own answer thinking about your decision from your own point of view and in your own particular circumstances
- Then compare your answer with your neighbour's answers

The second exercise connects values-based practice up with evidence-based practice in clinical decision-making.

Participants are asked to imagine that they have the warning signs of a potentially fatal disease and to make a choice between two NICE-approved treatments. One treatment (A) gives a 50:50 chance of immediate death or complete cure; the other treatment (B) guarantees a period of healthy remission but ending ultimately in death. The forced choice is that participants have to decide what **minimum period of remission** they would individually require to choose treatment B over the 50:50 offered by treatment A.

As with the first exercise people come up with very different answers ranging from never ('I would go for the 50:50 and get it over with') to fifty or more years. In the plenary discussion that follows they come to see that their very different choices (made on the basis of the same evidence base) reflect their very different individual values.

Table 1 gives the range of answers from a previous seminar. Participants' answers ranged from never ('I would just want to get it over with'), through short periods ('if I had twelve months that would be enough'), to many years ('for me, anything less than fifty years would make me go for the 50:50'). Then, as participants start to share their reasons for their choices, they come to see that the range of their answers reflects the diversity of their individual values.

Table 1. Choosing Treatment A over Treatment B Ranges

B	< 6 months	>6 months	1-5 years	5-10 years	>10 years	>25 years	>50 years
2	4	3	7	15	3	8	1

The link between participants' answers and their values may take some drawing out. Despite being in a seminar on values it can take a little while before 'the penny drops' that the reasons they had for choosing as they did are all about their individual values. But it is worth pressing groups to recognize this for themselves rather than just

explaining it. In getting to '*ah, yes, it's my values',* phrases like 'finishing my PhD is what's important to me' (the person who wanted an assured twelve months) or 'What matters to me is my children' ('if I can't have fifty years it would be better for my children to take my chance with 50:50').

The bottom line then is that clinical care depends on bringing together values-based with evidence-based practice, and the discussion thus delivers both learning objectives in one:

- From the way they talk about their reasons participants come to a shared understanding of values as 'what matters' or 'is important' to people (Learning Outcome 3)

- From seeing how different are the things that matter or are important to each other they see that it is their individually diverse values that drives their individually diverse choices (Learning Outcome 4).

A surprising diversity

An important aspect of the learning from this exercise is that people's values (and hence choices) are not only diverse but surprisingly so: even participants who know each other well often come up with answers very different from what they had expected of each other.

Reflecting on her experience after a surgical seminar one trainee surgeon described the rather unsettling sense of surprise that she and her fiancée felt and how this changed their understanding of how they made decisions with their patients.

> *"The 'forced-choice' exercise was a 'lightbulb moment' for me. I was sitting next to my partner of 6 years who is also a trainee surgeon and from a similar background to mine. We often discuss difficult clinical decisions at home and I feel that we share similar outlooks and ambitions. However, his 'value for X' (18 months) compared to mine (25 years) completely astounded me. If I could misjudge the values of the man I share my life with*

so profoundly, just how wrong might I be in assuming that I know what is important to my patients? He went on to explain his answer, which I fully understand and agree with, and I realized that, unless we ask, we will never know what matters to each other."

The surprising diversity of what matters to people (i.e. people's values) is why values-based practice is important for clinical decision-making as a partner to evidence-based practice.

Points to watch in delivering the exercises

There are two further points to watch out for specifically with the 'forced choice' exercise. Both are concerned with avoiding common misunderstandings about what the exercise is asking of participants.

- A preferred period rather than a minimum acceptable period

Participants may think the task is to choose the period of remission they would like from treatment B, rather than having to decide **the minimum period they would accept.**

So make this as clear as you can when introducing the exercise and reinforce the message when you circulate around the group to see how they are getting on. Test out people's responses a bit by saying, 'So you have chosen (say) 40 years – but what if it offered only 35? Would you still go for A or would this flip you to the 50:50 treatment B?'

- People in general not me in particular

The second misunderstanding is that the exercise is about what people in general would want rather than it being about an individual's choice and hence guided by that individual's particular values.

This is emphasized with a second power point slide that reinforces the message about individual choices by asking participants to think about just why they chose the period they did – and then compare with their neighbour.

Points to watch in taking plenary feedback

Flip chart or white board and pens available

An important point to watch out for here is to make sure you have a flip chart or white board available so that you can write up participants' individual answers as they feed them back. It is worth checking this in advance of the seminar. Power point is now so pervasive that either there is nothing to write on or the marker pens are empty!

Being able to write the feedback up so that it can be shared in real time is vital. The message from both exercises is in the diversity of answers participants give and their surprise at this diversity. Participants will have started to get this message in comparing notes in pairs. But it is strongly reinforced as they see the increasingly wide range of answers that others have come up with.

Feedback from all in a large seminar

With smaller seminars the presenter can take everyone's answers. With larger groups a selection from around the room is equally effective. With the 'three words' exercise, a good way to reinforce the message about diversity of responses is to take a few individual responses and then ask the group as a whole to raise their hand if they thought of a word not already on the list - usually a forest of hands goes up! Equally, with the 'forced choice' exercise, asking a few individuals to volunteer their timeframes, and then other participants to raise hands if their timeframe is an outlier can be very effective and prompt more discussion.

Points to Watch about Values and How to Respond

Discussion about values should be carefully handled throughout the seminar and indeed in any other training for values-based practice. Values are about what is important or matters to an individual. But 'individuals' of course includes seminar participants. So at any point sensitive issues may come up. These may involve personal or emotional issues or impinge on deeply held personal beliefs (e.g. religious or political beliefs).

- **Personal and emotional issues** are particularly likely to come up in case discussions where associations with a participant's own experience may be inadvertently evoked. But these issues may also come up with the two interactive exercises. The exercises are intentionally impersonal: the idea is to get participants thinking about the features of values important for understanding values-based practice before they start applying this in their clinical work. But the 'forced choice' exercise in particular may resonate with a participant's own experience and thus provoke strong emotions.

- **Strongly held personal beliefs** on the other hand may surface in the 'three words' exercise with discussion of the 'no right answer' point (above). The very idea of 'no right answer' may conflict with a participant's own religious or other strongly held personal values. There may equally be general concerns about 'anything goes' and moral relativism: a participant in one seminar commented 'Huh! So it's my values today and your values tomorrow!'

Responding to the issues

Just how such issues are handled is necessarily situation-specific. Clearly, they should never be simply dismissed. Responsiveness to individual values (what matters to the person concerned) is after all what values-based practice is all about. Understanding your own values furthermore, and how they interact with those of others, is important in this. Similarly, the ideological issues raised (about religious or political 'right' answers) are issues that values-based practitioners will encounter in practice.

The aim should thus be a balanced response: take the participant's concerns seriously while avoiding the seminar getting de-railed either by opening up personal issues that can't be worked through or by getting drawn into open-ended philosophical debates (about absolutism, relativism and the like). In the forced choice exercise for example a personal issue may be signalled by a participant's reluctance to engage (i.e. a reluctance to come up with a figure): so where this happens, encourage but avoid pushing too hard.

More ideologically motivated issues can be managed by:
1) Acknowledging the point ('this is taking us into deep philosophical waters'), then
2) Indicating opportunities to return to the point ('there is discussion of this in the readings we'll give out at the end of the seminar' or 'if you ask me at the end/drop me an email I can point you to some of the extensive literature on this' (see Read More, below)), and finally,
3) Bringing the discussion back to the key learning point that whatever the philosophical/ideological issues participants will inevitably encounter complex and conflicting values in practice.

Seminar Building Block Two -Extended Case Discussion

Values-based practice is a resource for everyday practice and case materials should be chosen accordingly to reflect the realities of participants' everyday experience

Prepared cases may be used, or delegates may be asked to bring cases from their own practice. The challenge here of course, with cases of either kind, is to protect confidentiality while providing enough detail for substantive engagement with the clinical issues.

Where possible groups should have participants with different perspectives, such as team members from different professional backgrounds and clinicians working with patients and family members.

Case discussion is best facilitated through group work followed by plenary feedback. Groups are given two tasks

1) To explore the **values issues raised by their case** from the perspectives of those involved. What do they think matters or is important to the patient, the clinician, etc; but also what wider values are in play and constraining the choices open to them (e.g. social and health economic values)?

2) To reflect on **their own values in response to the case**. What is important or matters to each of them individually about the issues arising from the case? To what extent do their values individually coincide with or depart from those of others in the group?

These questions help to embed the learning about values from the opening interactive exercises. Both questions produce much debate reflecting diversity of individual values (respectively of those involved in the case and of group members). This diversity in turn drives different views about what 'should' be done. These different views, moreover, and the diversity of individual values they

reflect, are features not of some exceptional 'hard case' but of an everyday clinical scenario.

The question arising then is 'what to do?' This leads back to values-based practice and the challenge of practical implementation.

A sample of the case scenarios used in these training sessions is included in **Part III.**

Seminar Building Block Three- Application to Practice

At this point in the training participants tend to divide into enthusiasts eager to take things forward and sceptics dubious of the practicality of values-based practice in the face of 'cuts' and other threats to services. The aim of this third session is to come to a balanced reconciliation of these two perspectives in a realistic approach to implementation.

For this part of the seminar participants should work in pairs. The task is that each participant has to come up with one small change (a 'tweak') that they can realistically make in their own practice. The grand plans of the enthusiasts are 'out'. Out too are the excuses of the sceptics. The required tweak to practice has to be one that is modest enough to be realistically achievable in the circumstances of the individual's actual practice. The test is that pairs have to persuade each other that their proposed 'tweak' really is do-able.

With individual 'tweaks' then shared in a final plenary, the take-home message for participants is that values-based practice offers a cost- and time-effective resource supporting best practice in their own individual areas of clinical care.

For an example of an effective tweak to practice that was suggested in surgical care, read 'What would you do, doctor?' below:

What would you do, Doctor? Ashok Handa, a consultant vascular surgeon, describes his own approach in his busy outpatient clinic:

I find most clinical decision-making is in grey areas where discussion often comes down to the patient not unreasonably asking: So what would you do doctor? And I wouldn't want to duck that. It's not helpful to patients to push the decision back to them. As surgeons, after all, we have considerable experience of how different options work out in practice: this can help a patient who is trying to make difficult choices in the context of facing potentially life-limiting diagnoses. But it's also not helpful to push our own decisions willy-nilly. This is what patient feedback from the workshops suggests we have been too inclined to do. It is what I now realize I have been in effect doing: my answer to 'what would you do?' has reflected my own values not those of the patient.

So now, instead of just replying with this or that option (however obvious it seems to me), I start by finding out more about what matters to this patient. Then I'm better able to look at what 'I' would do in terms of what matters from their point of view rather than from mine. So now when asked 'What would you do doctor?' my answer starts with 'Well I have some ideas about that but first, tell me a bit more about what's important to you?' And the dialogue then develops from there.

Outcome Measures

As with everything else in values-based practice the outcomes of training are highly context sensitive and impact measures should thus be carefully tailored to the particular aims of a given training event.

The direct outcomes of training (whether participants have actually learned anything) can be assessed using methods appropriate to the aspect of values-based practice covered, this gives specific suggestions for each main element of values-based practice. Assessment should also include feedback from participants (see **Part III** for a template feedback form).

The ultimate aim of these seminars is better patient care where 'better' means as defined by the values of the individual concerned. This follows contemporary good practice guidance as marked by the 2015 Montgomery judgment on consent. Again, various measures are available for assessing aspects of patients' experience of care, but the tools from these sessions aim to raise

awareness of values in paramedic practice and empower paramedics to have these conversations about values.

If you need to measure the impact values has had on clinical practice, the Collaborating Centre for Values Based Practice recommends considering the following:

- Greater knowledge of values
- Greater take-up of evidence-based guidelines
- Improved clinical outcomes
- Staff experience
- Patient experience
- Improved ethical care
    - Such as gaining informed consent
- Cost-effective use of resources
- Lower rates of litigation

Measures appropriate to these and other context-specific outcomes may be important in assessing the impact of training in a given context and would also contribute to the evidence-based surrounding values-based practice.

Part III - The Resources Library

The resources in these sections are free to view and can be downloaded in PDF form by accredited Faculty Partners.

Training Template Materials

A step-by-step guide to organising and running a seminar in values-based practice

Example seminar outlines

This section sets out the key steps we have found helpful for organizing seminars in values-based surgical care for clinical teams. Similar steps may be helpful for seminars with other groups in other clinical areas. The Education Advisory Committee within the College of Paramedics offers support with organising and running seminars, so please contact them if you need further guidance.

Case studies

Example cases are given in this section for

- Clinical Teams
- Medical students
- Professional graduates
- Other groups

The cases given are for illustrative purposes only. Case material should always reflect participants' level of experience and area of work.

Powerpoint presentations

This section includes the set materials to deliver the values-based practice seminar. This includes one PowerPoint presentation and six case studies.

Supplementary scenarios for non-registered clinicians

This section includes materials specifically for associate members of the College of Paramedics or non-registered clinicians. As with other materials in the Resources Library these are illustrative only and should be adapted appropriately for a given group or teaching context.

Feedback forms

Feedback is an important element in ensuring education surrounding values-based practice is fit for purpose. As well as implementing feedback after local delivery, the Collaborating Centre for Values Based Practice is always keen to expand and evolve its delivery of values-based practice.

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