



Values-based Practice in Diagnostic & Therapeutic Radiography A Training Template

HANDBOOK & TRAINING RESOURCES

Edited by
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In collaboration with
The College of Radiographers &
The Collaborating Centre for Values-based Practice in Health and
Social Care



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Contributors and Acknowledgements

This Handbook is based on the original document, Values-based Practice in Clinical Care¹, developed by the surgical care team of the Collaborating Centre for Values-based Practice in Health and Social Care; with the support of a wide range of colleagues, patients and Collaborating Centre Partners.

The main editors for this original work were Ashok Handa, Tutor for Surgery in Oxford and Co-director of the Collaborating Centre, and Bill Fulford, Director of the Collaborating Centre.



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Bill Fulford

Bill is a Fellow of St Catherine's College and Member of the Philosophy Faculty, University of Oxford; and Emeritus Professor of Philosophy and Mental Health, University of Warwick Medical School. Values-based practice builds on his work in philosophical value theory. As Special Adviser for Values-Based Practice in the Department of Health (2007 – 2011) Bill led on a number of early training and policy initiatives combining evidence-based and values-based approaches.

A small team, comprising of committee members of the Association of Radiography Educators (ARE) and other interested radiography educators, have adapted materials from the original Handbook for use by both diagnostic and therapeutic radiographers. The team members are:

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The scenarios included in this Handbook have been piloted with radiographers and students at study days and university teaching sessions. We are grateful to these individuals for their input.

Introduction

This chapter introduces the Handbook and describes the accreditation process supporting the development of values-based practice through shared learning.

1. Origin and Aims
2. The Structure of the Handbook
3. Accreditation and Shared Learning

1. Origin and Aims

Since its introduction in the early years of this century training in the skills for values-based practice (VBP) has been widely adopted in mental health and primary care with counterpart initiatives in related areas such as values-based commissioning. The aim of this Handbook is to support extension of VBP to secondary and tertiary care.

The Handbook is based on a program in Values-based Surgical Care developed by the Nuffield Department of Surgical Sciences, Oxford Medical School, in partnership with the Collaborating Centre for Values-based Practice in Health and Social Care at St Catherine's College. It thus reflects the expertise of a wide range of stakeholders both within and beyond surgery (as detailed in our Acknowledgments).

This Handbook is an extension of the initial work, to encompass diagnostic and therapeutic radiography, providing profession-specific materials that can be used for VBP training. We acknowledge that some patients may have unusual or controversial values. Addressing these values is not within the remit of this Handbook. Challenging such misplaced values amongst the public at large is also not within the remit of this document. Instead, it is aimed at the education of radiographers in the application of VBP, so that they can engage in shared evidence-based decision-making with their patients, using dialogue about values. We acknowledge that as a profession our role is evolving with the Public Health Prevention Agenda and Prevent, but there are other more pertinent routes for addressing these topics.

This Handbook is simply related to improving the patient experience; however, it remains a work in progress. The Training Template includes a number of guiding principles and key ideas about VBP. We hope the sample materials and training protocols included will prove helpful, but successful implementation of VBP depends on development and adaptation of the approach, in order to meet the particular contingencies of a given clinical area and service context. Extending VBP to secondary and tertiary care will thus be an iterative process. The Training Template set out in this manual is a starting point, but the aim is that it should be progressively developed and enriched through feedback and contributions from other areas of practice.

Raised awareness and a whole system approach

The starting point, and a key skill for VBP in clinical care, is raised awareness of values and it is with this that the materials set out in Part II of the Handbook (The Training Template) are primarily concerned.

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 (described in Part I). The Handbook should thus be read as standing alongside, and in partnership with, initiatives in other areas of VBP supported by the Collaborating Centre.

Read More: For further information on other aspects of the work of the Collaborating Centre please go to valuesbasedpractice.org | **what do we do** | **Key areas of Collaboration** using the following link [Key Areas of Collaboration](#).

For further information about the work of the ARE and study days please go to <https://www.sor.org/career-progression/educators/association-radiography-educators>

You can also find us on Facebook and Twitter @AofRadEducators

2. The Structure of the Handbook

The Handbook is divided into three main parts:

Part I - About Values-Based Practice. A brief introduction to VBP, focusing on its role in clinical care, this part of the Handbook is divided into three sections covering key points about the 'What?', the 'Why?' and the 'How?' of VBP, illustrated with examples from diagnostic and therapeutic radiography.

Part II - The Training Template. This section is based on our experience of developing VBP in radiography. The Template includes:

Section 1. The Basic Training Model. This consists of three Seminar Building Blocks covering, respectively, interactive exercises introducing values and VBP, case discussion, and take-home messages.

Section 2. Details of Seminar Building Block 1. The interactive exercises in Seminar Building Block 1 are key to developing skills for VBP. This section gives the learning outcomes and points to watch out for when running the exercises and explains how they support VBP training in clinical care.

Part III - The Resources Library. This section provides a range of materials for seminars in VBP building on the Basic Training Model. The materials are drawn partly from those developed for the diagnostic and therapeutic radiography seminars on which the Training Template is based and partly from the Collaborating Centre website. The Resources Library includes:

- A. Training Template Materials.** Five sections of resource materials, including a step-by-step guide to facilitating a VBP seminar, example seminar outlines and clinical cases, other seminar materials (e.g. PowerPoint presentations and handouts), and exemplar administrative documents (e.g. invitations and feedback forms). All these resources are available to download free (subject to accreditation of an individual to carry out training by the Collaborating Centre, see Introduction Section 3, Accreditation and Shared Learning).
- B. Collaborating Centre Website Materials.** This part of the Resources Library is made up of five sections providing links to relevant areas of the Collaborating Centre website, including a teaching and learning framework, training manuals, values-based policy and practice guidance, search strategies for retrieving literature on values, and an annotated reading guide.

3. Accreditation and Shared Learning

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

The ARE have already facilitated two successful study days on VBP in radiography and its committee members have facilitated teaching sessions with student radiographers at their own universities. Our aim has always been to share this material, which is the reason for the publication of this Handbook, so that all radiographers can gain an understanding of VBP and 'spread the word'.

For this reason, we encourage anyone planning to use the Handbook to contact one of the editorial team with a view to joining a training session in VBP. You are welcome to attend more than one session, but just one session will help to bring the whole field to life and give you a deeper understanding of what VBP is all about. This in turn will give you a firmer foundation on which to develop and adapt the training template to meet the particular contingencies of your own area of practice.

Attending a training session makes you a Faculty Partner, accredited to offer sessions to others and help build the field by contributing additional teaching and learning materials to the Training Template. In this way VBP will remain an open and outward-looking discipline growing through shared learning across an increasingly diverse community of clinical care.

Contact the ARE team via AssociationofRadiographyEducators@outlook.com

Contact the Collaborating Centre via their website [Contact us](#)

Part I - About Values-Based Practice

This chapter provides a brief introduction to values-based practice. Illustrated with clinical examples from diagnostic and therapeutic radiography, it covers key points about the 'What?', the 'Why?' and the 'How?' of values-based practice in secondary and tertiary care.

1. What is values-based practice?
2. Why is values-based practice important clinically?
3. How is values-based practice implemented?

'Read More' details to further information about values-based practice are included throughout.

Part I: 1. What is values-based practice?

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

Case Example 1: Mrs Jones' Knee (taken from the VBP in Clinical Care Handbook)

Mrs Jones (not her real name) was referred to an orthopaedic surgeon with a painful arthritic knee. The best option with this condition, the surgeon explained, is knee replacement. There were risks of course as with any operation but with a prosthetic knee joint she would very likely end up pain-free.

Mrs Jones thanked the surgeon saying 'I'm so pleased, doctor, I'll be able to garden again'. 'Well, tell me a bit more about that' the surgeon replied. 'You see', Mrs Jones explained, 'it's not the pain I'm worried about. It's the fact I can't bend down well enough to do my gardening.'

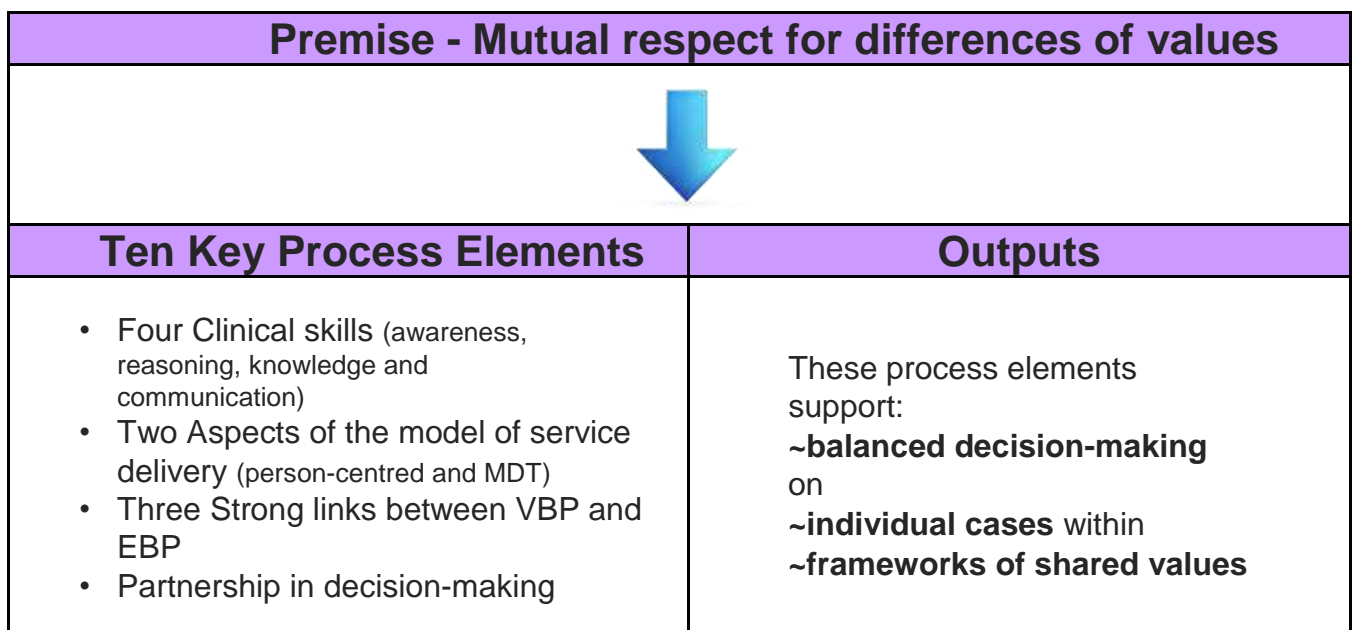
The surgeon explained that with the prosthetic joints currently available she would be no more mobile, and possibly less so, post-op. After a brief further discussion Mrs Jones opted for conservative management.

Most people with painful arthritic knees want to get rid of the pain. It was natural therefore that the surgeon should assume this was what mattered to Mrs Jones. No doubt it did matter, but what mattered more to her was to recover the mobility she needed to do her gardening. It was therefore Mrs Jones' *individual values* (what mattered most to her) that determined her shared decision with the surgeon to opt for conservative treatment.

Read More: For further clinical examples see **Part III - The Resources Library, A. Training Template Materials, Section 3.**

Summary of VBP

The process elements of VBP are summarised in the diagram below. Framed by a premise of mutual respect, ten key process elements support balanced decision-making on individual cases within frameworks of shared values.



Part I: 1. What is values-based practice?

Mrs Jones' Knee and VBP

Mrs Jones' story illustrates a number of key points about how VBP works clinically:

- **Awareness of values is the essential first step**

The full ten process elements of VBP may look rather daunting. Each element is important in different circumstances but, as in Mrs Jones' story, it is the first element (raised awareness of values) that is the key. The training programs described in this Handbook always start with raising awareness.

- **Not the only 'tool' in the tool box**

In practice many other values besides those of clinician and patient have an impact on practice. The options available to Mrs Jones, for example, reflect health economic values which in turn reflect political and social values.

This is why VBP is best understood as one among many 'tools' now available for working with values in health care. Other tools, besides VBP and health economics, include ethics and decision analysis.

- **I don't have time for this**

With services under ever-growing pressures a natural reaction to talk of 'dialogue about values' is to say 'Great – but I just don't have time for all that!'

Mrs Jones' story shows to the contrary just how cost- and time-effective dialogue about values can be. It took the surgeon a few extra minutes to agree with Mrs Jones that given what mattered to her (i.e. her values) they should go for anti-inflammatory medication and physiotherapy rather than a knee replacement. But the result was a 'win' for everyone:

- Mrs Jones got back to her gardening
- The surgical team saved a precious resource of time
- The NHS avoided several thousand pounds of wasted operating and related costs

- **Values and evidence**

Mrs Jones' story although focusing on values also reminds us that clinical decision-making should always be evidence-based as well as values-based.

The decision to opt for conservative management of her arthritic knee combined the surgeon's knowledge of the advantages and disadvantages of the evidence-based options available with what mattered to Mrs Jones (i.e. her individual values).

Part I: 1. What is values-based practice?

Case Example 2: Hannah Walker

Hannah Walker (not her real name) is a 35-year-old female booked into the Imaging Department for an MRI scan, who arrives in the department visibly distressed. Hannah tells the receptionist that she is claustrophobic, and feels very nervous about the scan. She has been referred for a scan of her Internal Auditory Meati (IAMs); the request form from her GP has been vetted and states a clinical history of tinnitus, and is questioning a possible diagnosis of an Acoustic Neuroma.

The Imaging Assistant calls Hannah into the changing area and starts to work through the MRI safety checklist. At this point Hannah bursts into tears and so the Imaging Assistant calls on a Band 7 Lead MR radiographer, who has extensive experience, to come and talk to Hannah. The radiographer starts to reassure the patient that the scan is very quick – usually less than 10 minutes – and that it will be worth it to find out what is causing the tinnitus.

Hannah explains that she has had the tinnitus for over 10 years, and that it does not bother her, as she is used to it. She goes on to say that she recently changed GP and on her new patient questionnaire declared the tinnitus. Hannah's new GP referred her for the MRI scan at that point, even though Hannah had told her GP she was claustrophobic.

In light of what Hannah has told the radiographer, the radiographer draws on her experience and the research evidence base and decides to explain to Hannah what an Acoustic Neuroma is. She also asks Hannah if she has any hearing loss, to which Hannah replies that she does not, it is just tinnitus. In discussion with the radiographer Hannah decides not to proceed with the MRI scan today, instead she agrees to make another appointment to see her GP to discuss this further, as she does not feel that the discomfort she would suffer during the scan would help her and it is unlikely that it would improve her tinnitus. The radiographer documented the discussion with Hannah and ensures that this information is sent back to the GP (the referrer).

Most people with tinnitus want to get rid of it. It was natural therefore that the GP should assume this was what mattered to Hannah. No doubt it did matter, but what mattered more to her was that she was claustrophobic and this took over how she was feeling. It was therefore Hannah's *individual values* (what mattered most to her) that determined her shared decision with the radiographer not to have the MRI scan.

Hannah Walker and VBP

Hannah's story also illustrates a number of key points about how VBP works clinically:

- **Awareness of values is the essential first step**

In Hannah's story, just as in Mrs Jones' story, the first element (raised awareness of values) is the key. The training programs described in this Handbook always start with raising awareness.

- **Not the only 'tool' in the tool box**

Once again we can see that the options available to Hannah also reflect health economic, political and social values.

This is why VBP is best understood as just one among a number of 'tools' now available for working with values in health care. Other tools, besides VBP and health economics, include ethics and decision analysis.

Part I: 1. What is values-based practice?

- **I don't have time for this**

With services under ever-growing pressures a natural reaction to talk of 'dialogue about values' is to say 'Great – but I just don't have time for all that!'

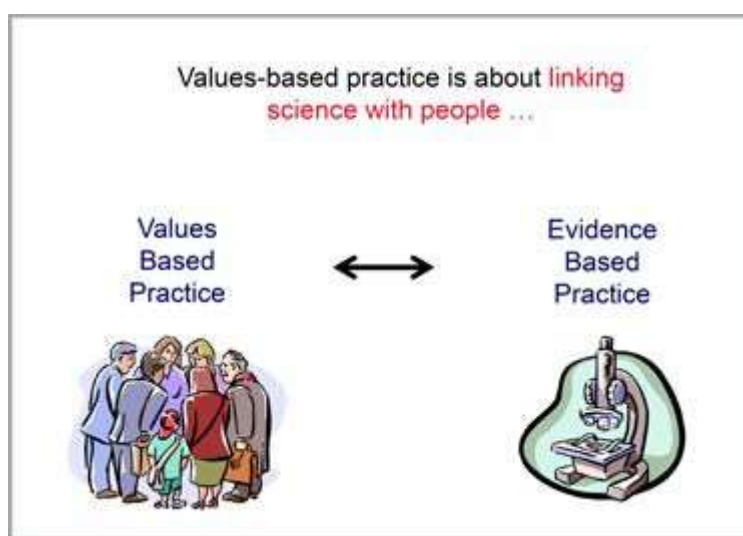
Hannah Walker's story shows to the contrary just how time-effective dialogue about values can be. It took the radiographer a few extra minutes to find out why Hannah was upset, and what really mattered to her (i.e. her values). But the result was a 'win' for everyone:

- Hannah did not want the MRI scan and was able to make a decision that she was comfortable with; she was also given the opportunity to discuss her concerns further
- The radiographer considered what was important to Hannah and was able to give her a choice

- **Values and evidence**

Hannah's story, although focusing on values, also reminds us that clinical decision-making should always be evidence-based as well as values-based.

The decision to opt for cancelling the MRI scan combined the radiographer's knowledge of the advantages and disadvantages of the evidence-based options available with what mattered to Hannah (i.e. her individual values).



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

Read more about values-based practice

For details of all aspects of values-based practice and an annotated reading guide, please go to valuesbasedpractice.org | **More About VBP** using the follow link [More about VBP](#).

The clinical impact of various elements of values-based practice, separately and together, is illustrated through a series of extended case examples in *Essential values-based practice: clinical stories linking science with people*²

Part I: 2. Why is values-based practice important clinically?

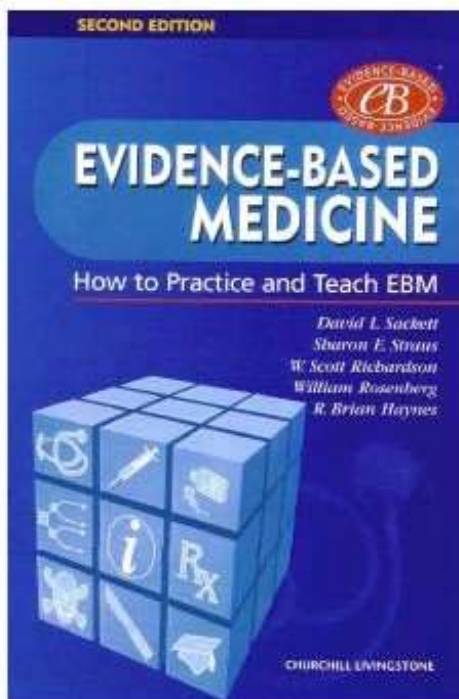
Shared decision-making based on dialogue about values is important clinically because it improves patient outcomes and offers a time and cost-effective way of providing evidence-based care.

The story of Mrs Jones' knee (Part I, Section 1) makes this point. Most people in Mrs Jones' situation would have wanted knee replacement because for most people getting rid of the pain is their priority. But for Mrs Jones, given what mattered most to her (to be able to garden again), this would have made a bad situation worse (by further reducing her mobility). This is why in a decision made with the surgeon Mrs Jones opted for conservative treatment. The story of Hannah Walker also illustrates this point; Hannah was not really interested in finding out the cause of her tinnitus, she was more worried about having an MRI scan. Once again, shared decision-making based on what was important to Hannah contributed to the decision for her not to have the MRI scan.

The importance of shared decision-making based on values has been spelled out in both evidence-based guidelines and in codes of practice. In the UK, following the 2015 Supreme Court 'Montgomery judgment', shared decision-making based on dialogue about values is now the legal basis of consent to treatment.

Evidence-based Guidelines

Evidence-based medicine is about basing clinical decisions on best research evidence. But as David Sackett, the inaugural Director of Oxford's Centre for Evidence-based Medicine, spelled out; "it is also about combining best research evidence with experience and with values".



In their pathfinder textbook³ 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" (p1).

Sackett's emphasis on combining evidence with values is reflected in contemporary evidence-based guidelines. In the UK for example all NICE guidance emphasises that treatment and care should take into account patients' individual "needs, preferences and values" (see for example <https://www.nice.org.uk/guidance/cq181>)

Part I: 2. Why is values-based practice important clinically?

Your responsibility

The recommendations in this guideline represent the view of NICE, after careful consideration of the evidence available. When exercising their judgment, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients and service users. The application of the recommendations in this guideline is not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

NICE (the National Institute for Health and Care Excellence) is the body responsible for reviewing and issuing evidence-based guidelines for the UK's National Health Service.

The College of Radiographers (CoR) promotes imaging and radiotherapy science and practice for the benefit of all. The CoR do this in a number of ways through:

- Standards for education and practice
- Promoting and conducting research
- Listening to patients and service users

The CoR research strategy⁴ focuses on the following specific objectives:

- Supporting professional development
- Building professional credibility through research

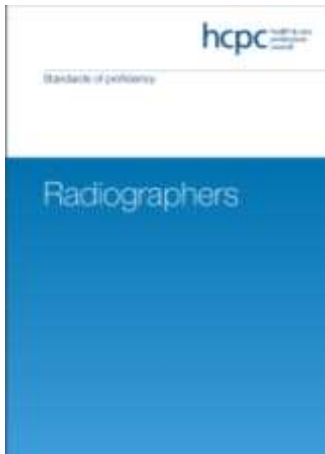
It should be noted that the CoR research strategy is not exclusive to the objectives above; it will also underpin many of the other strategic objectives to ensure that radiography continues growing as an evidence-based profession, with an emphasis on improving patient care and service delivery (CoR, 2017) <https://www.sor.org/learning/document-library/college-radiographers-research-priorities-radiographic-profession>

Part I: 2. Why is values-based practice important clinically?

Codes of Practice

The importance of connecting evidence with values is emphasised similarly in professional codes and guidelines. The Health and Care Professions Council (HCPC) includes a number of statements to this effect in its Standards of Proficiency for Radiographers⁵.

Statements 2, 5 and 8 of these Standards clearly tell us that we must:



- 2.3. understand the need to respect and uphold the rights, dignity, values, and autonomy of service users including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing
- 5.1 understand the requirement to adapt practice to meet the needs of different groups and individuals
- 8.5 understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions

Montgomery 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 judgment⁶.



Montgomery consent means:

Clinicians engaging 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.

Exactly how the Montgomery judgment will be interpreted in different contexts remains to be seen. It is important to note that Montgomery consent is based on *patients' individual values being taken into account* in shared clinical decision-making.

Part I: 3. How is values-based practice implemented?

In Mrs Jones' story and Hannah Walker's story (Part I, Section 1), their values came to light as a result of a chance remark.

The surgeon had the skills to pick this up and explore its implications with Mrs Jones, and the radiographer with Hannah Walker. 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'. While doing so we recognise that patients may make what seem to be unwise decisions and we need to respect those decisions. The Mental Capacity Act (2005)⁷ is underpinned by a number of statutory principles, the first of which is that everyone (aged 16 or over) must be assumed to have full capacity to make legal decisions; known as the 'right to autonomy'. People cannot be assumed to lack capacity because of age, appearance, condition or behaviour. Principle 3 of this act relates to unwise decisions: "People have the right to make decisions that others might regard as unwise or eccentric." Everyone has their own values, beliefs and preferences which may not be the same as those of the practitioner.

What would you do, doctor?'

Angela Arnold, an interventional radiologist, describes her own approach to patients on her busy interventional list:

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 specialists in our field, 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 realise I have in effect been 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.

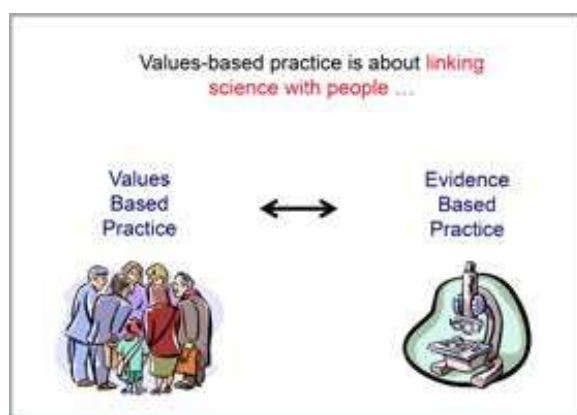
Interventional radiology involves decisions about procedures for potentially life limiting conditions such as femoral artery stenosis. Faced with such decisions patients naturally ask Angela what she would do. She, after all, is the expert and in the past she has not shied away from saying what she would do. But now, adopting a values- as well as evidence-based approach, she finds out what matters to the individual concerned (time in hospital, risk of stroke/cardiac arrest, etc.) that bears on the evidence-based options available. With this additional brief exchange, she is able to say 'what she would do' but from the perspective of her patient's values rather than her own.

Part I: 3. How is values-based practice implemented?

Linking science with people in vascular surgery

Although a very different area of practice, there are clear parallels between Angela's approach to her interventional radiology patients and the stories of Mrs Jones' knee and Hannah Walker (Part I, Section 1).

In all contexts: 1) **raised awareness** of values is the key; 2) there are **other values and other tools** for working with values in play (e.g. the background health economic values and processes constraining the options available); 3) the intervention is **time-effective** – it involves no more than a tweak (albeit a crucial tweak) to Angela's previous practice; and 4) the decision is **evidence-based** as well as values-based.



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

A training program in values-based radiography

Our program in values-based radiography builds on and adapts the wide range of training materials already available for values-based practice in primary care (see **Read More**, below).

We are at an early stage in the process but have thus far piloted short training sessions with several groups:

- Radiography students, on both the diagnostic and therapeutic radiography courses at four different universities
- Radiographers at two study days

Part I: 3. How is values-based practice implemented?

The basic model of training

Details vary (see **Read More**, below) but for each group, training sessions follow the same basic model: a brief introduction to values and VBP followed by extensive discussion of cases from everyday practice.

TABLE 1 - The Basic Training Model

Seminar Content	Learning Outcomes
<p>BRIEF INTRODUCTION TO VBP</p> <p>Two brief (10 minute) interactive group exercises plus plenary discussion</p>	<p>Raised awareness of</p> <ol style="list-style-type: none"> 1) Many meanings of 'values' 2) Diversity of individual values 3) How this diversity drives different choices from the same evidence-base
<p>EXTENDED CASE DISCUSSION</p> <p>Small group work plus plenary discussion around everyday case scenarios</p>	<p>Embedding the above and applying to decision-making in everyday practice</p>
<p>TAKE HOME TWEAKS</p> <p>Reflection in pairs on personal practice plus plenary feedback: aim is for each delegate to come up with one small change they can make to their own practice</p>	<p>Further embedding the above by applying to decision-making in each delegates' own everyday practice</p>

The ARE have worked with Bill Fulford and Ashok Handa over the past two years to develop these training materials and to make them relevant for diagnostic and therapeutic radiography. We have gained CPD Now endorsement from the College of Radiographers for the training materials and we are keen for them to be used by radiographers training staff and students in VBP.

We are grateful for all of the input that we have had from colleagues, students and service users.

We would be very pleased to provide support if you are interested in developing your own programme – please see:

Valuesbasedpractice.org

[Becoming a Project Partner](#)

SoR.org

[Association of Radiography Educators](#)

Read More: The timings shown in Table 1 are for a two hour session. For full seminar outlines, including details of the interactive exercises, please see **Part II – The Training Template, Section 2. 'Details of Seminar Building Block 1'** and corresponding sections of **Part III – The Resources Library**

Part I: 3. How is values-based practice implemented?

From training program to template

Just as the training program in values-based surgical care builds on resources developed originally in primary care, so the template needs to be further developed and adapted to meet the particular circumstances presented by clinical decision-making in other areas of secondary care.



The materials given in this Handbook are based on our experience of developing training in values-based radiography. We hope you will find these useful as a template on which to build. But the Training Template is not prescriptive. The idea is that it should be developed in a process of mutual learning between different clinical areas.

Read More: For details of the training methods used for values-based radiography, see **Part II – The Training Template, Section 1.3. ‘Three seminar building blocks’**, and **Section 2. ‘Details of Seminar Building Block 1’**. Sample training resources, including seminar outlines, PowerPoint presentations and supporting handouts, are given in **Part III - The Resources Library**.

Part II – The Training Template

This chapter describes training in raised awareness of values, which is the foundational clinical skill needed for values-based practice, and illustrates its applications with diagnostic and therapeutic radiographers.

1. The Basic Training Model
2. Details of Seminar Building Block 1

Part II: 1. The Basic Training Model

A fully developed values-based practice includes no less than ten distinct elements (see Part I, Section 1). Underpinning all these, however, is the first of the values-based clinical skills, raised awareness of values.

This section of the training template describes the basic model for training in raised awareness of values:

- 1) Learning objectives
- 2) The importance of context
- 3) Three seminar building blocks
- 4) Outcome measures

Part II, Section 2 will look in more detail at two interactive exercises at the heart of the Basic Training Model.

1) Learning objectives

Training in raised awareness of values has three specific learning objectives:

- i. To raise awareness of the **range of values** important in healthcare (including needs, preferences, etc. as well as ethical values)
- ii. 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)
- iii. A shared understanding of values as '**what matters**' or '**is important**' to people
- iv. To raise awareness of how **different values** drive **different choices** (even with the same evidence base)

Read More: For further details of these three learning objectives and how they are delivered, see '**3) Three Seminar Building Blocks**' (below) and the interactive exercises described in **Part II, Section 2. 'Details of Seminar Building Block 1'**.

2) The importance of context

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

Part II: 1. The Basic Training Model

3) Three seminar building blocks

Skills training of any kind works best if it is carefully tailored to such factors as participants' clinical area and level of experience. This is why in contributing to the range and diversity of seminar materials available faculty partners can play a vital role in the on-going development of values-based clinical care (see Introduction, Section 3 'Accreditation and Shared Learning').

There are however three generic building blocks on which training in raised awareness of values should build:

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

These are summarised in Table 2 below.

TABLE 2 - Three Generic Building Blocks

Seminar Content	Learning Outcomes
<p>Block 1. INTERACTIVE EXERCISES</p> <p>Two brief (10 minutes each) group exercises plus plenary discussion introducing ideas about values and VBP</p>	<p>Raised awareness of:</p> <ol style="list-style-type: none"> 1) Range of values important in healthcare 2) Diversity of individual values 3) Different values drive different choices (with the same evidence base) <p>Understanding of VBP as:</p> <ol style="list-style-type: none"> 1) A resource for working with individually diverse values 2) A partner to evidence-based practice
<p>Block 2. CASE DISCUSSION</p> <p>Small group work plus plenary discussion around everyday case scenarios</p>	<p>Embedding the above by exploring the diversity of values impacting on all areas of everyday practice</p>
<p>Block 3. TAKE HOME TWEAKS</p> <p>Work in pairs plus plenary feedback on changes participants can make to their individual practice</p>	<p>Applying learning to own practice through a small 'do-able' change (a 'tweak') carefully tuned to the context of each individual's practice</p>

Part II: 1. The Basic Training Model

Block 1. Interactive Exercises

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 recognise this for themselves.

- **The 'three words' exercise**

Key message: the surprising diversity of values is why we need VBP

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.

Although there will be some overlaps, everyone is surprised to find they have come up with different words. Building on this the presenter gives a brief introduction to values-based practice as a resource for working with diversity of values in healthcare.

- **A 'forced choice' exercise**

Key message: different values drive different clinical choices

The second exercise connects VBP 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. Treatment A gives a 50:50 chance of immediate death or complete cure; 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** he or she would individually require to choose treatment B over the 50:50 chance 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 forty 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.

The bottom line then is that clinical care depends on bringing together values-based with evidence-based practice.

Read More: These exercises are described in more detail in **Part II, Section 2. 'Details of Seminar Building Block 1'**.

Part II: 1. The Basic Training Model

Block 2. Case Discussion

There are many ways in which case discussion can be used in clinical skills training. Ethical dilemmas for example provide a powerful way of stimulating debate in ethics.

VBP by contrast is a resource for everyday practice and case materials should be chosen accordingly, i.e. 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: team members from different professional backgrounds, for example, 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:

- 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)?
- 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 learning about values from the opening interactive exercises of Block 1. 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 VBP and the challenge of practical implementation.

Part II: 1. The Basic Training Model

Case study examples for diagnostic and therapeutic radiography

Here are some case study examples from diagnostic and therapeutic radiography that can be used during the training sessions, these have been developed by the ARE committee members.

Case 1: Gareth

Gareth is a 35-year-old male who was being treated for metastases which had spread to his spine from an unknown primary.

On day one of treatment he was an outpatient and was able to walk by himself for treatment. By day three he could no longer walk, had been admitted as an inpatient, and a further two areas had been identified for treatment. He was in a lot of pain despite being medicated with painkillers prior to coming down for treatment from the ward.

On day four he came down for treatment as normal, however, he was unable to tolerate the treatment due to the pain. When Jeanette, the radiographer, went into the room Gareth told her that he did not wish to have any further treatment and that he wanted to have his pain managed by medication and to spend the remainder of his time with his family. Jeanette clarified with Gareth that he no longer wished to continue with his treatment to ensure that she had understood him correctly. Gareth re-confirmed that was his wish. Jeanette and her colleagues transferred Gareth back to the ward, documented events in his treatment card and then called the registrar on the team to tell him what had happened. The registrar took the view that it was 'the pain talking' and that it was in Gareth's best interests to get him down again for treatment the next day. The consultant however took a different line when he came to the department later that day. Having talked with Gareth on the ward and reviewed the latest scan (confirming that there was another metastasis present) he agreed that there should be no further treatment.

Case 2: Colin

Colin is an 82-year-old reasonably fit man. His General Practitioner (GP) has requested a colonoscopy due to rectal bleeding. Colin is a diabetic and requires an early morning appointment.

He phones to confirm his appointment and the outpatient's department ask him whether they should book him hospital transport. He is very insulted because he can drive and why would he need hospital transport? He is not old! They did not ask him whether he could drive, just assumed because of his age that he would not be driving.

Colin is very concerned about what will happen after the procedure because he will need to eat due to his diabetes. He does not want to appear awkward so won't bring his own sandwiches but believes he can't ask for sandwiches without mayonnaise and, in his opinion, "these days" they all have mayonnaise in! This is adding extra stress for him regarding the procedure.

He is offered a sandwich after the colonoscopy but the radiographer's body language makes him feel that he is being a nuisance, because now she has to contact the kitchen regarding a different sandwich to the one they have for him.

Part II: 1. The Basic Training Model

Case 3: Edith

80-year-old Edith Smith with query fractured neck of femur (?#NOF). Edith presents to Accident & Emergency (A&E) via the walk in centre with impacted #NOF. She is in a great deal of pain and having had an X-ray examination it is confirmed #NOF requiring surgery. However, no one in A&E explains what will happen next or how long it will be before anyone tells her and her husband what is happening. Her husband is diabetic and does not want to leave her side but it is getting to a point where he needs to eat, and he hasn't brought any insulin with him as they were not expecting to be this long.

Many staff walk past the trolley in the A&E bay but no one makes eye contact with them. Four hours pass before finally they are informed that Edith will be admitted. When asking about whether her husband can have something to eat they are informed there is tea/coffee and biscuits available for relatives round the corner but no one has previously told them this. Finally, the staff are aware that Edith's husband requires insulin and food, but up to this point no one has asked them if they are okay and they do not want to be a trouble.

Case 4: Emily

Emily Bottomley is a 70-year-old female attending the clinical imaging department for an X-ray examination of her knee. The department is an open access service meaning that she could not make an appointment. Emily has attended at a particularly busy time of the day, on a day that is known to have a large number of clinic patients presenting. As a result, the waiting room is noisy with a large number of people coming and going. Emily is becoming agitated at having to wait for her examination and her daughter, Mary, has complained to the reception staff.

Ruby, an assistant practitioner, calls Emily from the waiting room to change into a gown prior to her examination. Emily and her daughter follow Ruby to a changing area. Emily does not want to confirm her name when Ruby asks and is not keen to change into a gown. Mary explains that her mum has early onset dementia and has become distressed waiting for a long period in the noisy waiting room.

Ruby is concerned that there may still be a period of time to wait in the changing area because the X-ray examination rooms are currently occupied. She explains this to Emily and Mary. Ruby knows that the department is usually calmer for a period of time after lunch on that particular day. She explains this to Emily and Mary, they decide to go to the hospital cafeteria for lunch and return in an hour.

Ruby shows Emily and Mary the way to a separate sub-waiting area. She explains that it will be quieter than the main area and they return there after lunch. Ruby has been watching for their return. She has liaised with her team and an X-ray room becomes free for them to proceed. Emily is calmer having had her lunch and time away from the waiting area that distressed her. She is happy to confirm her details, to change and to complete the examination. Emily and Mary thank Ruby for her help.

Part II: 1. The Basic Training Model

Case 5: Fred

Fred Bloggs is a 65-year-old gentleman who is having a single course of radiotherapy to treat his cord compression. He arrives via hospital transport from another hospital at 13:00 for his treatment.

His return journey is booked for 15:00, but at 16:00 his transport has still not arrived. When the radiographer and receptionist check the online booking system it shows that his booking has been moved to 18:00. When transport is rung at 16:00 to query this the receptionist is informed that the driver is currently dropping off a patient and they are about half an hour away.

The radiographer goes to inform Fred of this and check that he has everything he needs. He is slightly worried that he will miss his medication but otherwise states he is ok. At 17:00, there is still no sign of the transport, the receptionist rings again and is informed that the driver is still half an hour away due to an accident that has happened.

The radiographer goes to see Fred again who states he is okay. The radiographer notices that Fred keeps looking at his phone and assumes that he is checking the time. At 17:45 transport is rung again and they state that it will be another 15 minutes before transport arrives.

This time when the radiographer goes to see Fred, he mentions that his son is probably waiting for him at the other hospital, whilst looking at his phone. The radiographer asks Fred if he would like her to try and phone his son from reception to let him know where Fred is. Fred agrees, but unfortunately, there is no answer from his son.

At 19:20, the transport finally arrives to pick up Fred, when Fred mentions how long he's been waiting the driver states that he isn't the only one and that one of the other passengers has been waiting even longer. Fred is anxiously looking at his phone saying how his son is waiting for him and wondering where he is. The response he gets is that it will still be another 45 minutes before he gets back to the hospital as they have to drop the other patients off first.

Case 6: Jane

Jane Jones has found a lump in her breast and has been referred to the one stop clinic. Mark, her husband, cannot go to the clinic appointment with Jane as she does not want to worry her friends and family. Jane goes to the appointment alone. She is more than a little anxious about her visit to clinic and what the lump might be.

At clinic she is the first patient of the day. She is greeted by the friendly staff and asked to change into a gown and sit in a sub-waiting area. Jane sits in the sub-waiting area for quite some time in her gown.

Jane is cold and anxious; she can hear the discussions of the staff who are sitting in a room just along the corridor from her. She does not want to hear about the radiographer's difficulties in getting a matching toilet for her bathroom suite. She wants somebody to offer to keep her warm and to get on with her examination. Jane also wants to go to the toilet but there are no clear signs where they are and there is nobody visible to ask. Jane does not want to interrupt the staff. She does not want to cause a fuss but is starting to shiver now as she is so cold.

Eventually (about 20 minutes and many more varied conversations later) a member of staff calls Jane into the examination room and briefly mentions that the equipment takes quite a while to warm up on cold days. Jane smiles politely.

Part II: 1. The Basic Training Model

Case 7: Alan

A 75-year-old patient, Mr Alan Jones, has arrived in the radiotherapy department for his pre-treatment CT scan. He has travelled with his wife and the journey has taken them an hour to complete. This included a trip on the M25 which is something Mr Jones tries to avoid. Due to traffic they are 10 minutes late for their appointment which has made him very anxious.

They are directed to take a seat in the CT waiting area. After waiting 30 minutes a radiographic assistant practitioner (AP) comes out and asks Mr Jones for his name and whether he has checked in. The AP then returns to the CT control room. Upon checking the patient booking system, the AP notices that Mr Jones is meant to be at the department's satellite centre, which is only 15 minutes from his house for his CT scan. The AP discusses this with a senior radiographer and between them they decide that as Mr Jones should be at the other centre and they have got a busy afternoon that Mr Jones should be sent away without having his CT scan done and told to go the correct department.

The AP goes out to inform Mr Jones and his wife of this. Mr Jones doesn't say anything he just leaves.

Case 8: James

A diagnostic radiographer called a 5-year old child (James) in for an X-ray examination of his pelvis and hips. Once, in the room, the radiographer introduced herself and asked James if he could tell her when his birthday is. James' mother responded and said that he was 'non-verbal.' The radiographer went on to clarify James' full name, date of birth and first line of his address with his mother.

Recognising that James had some additional learning needs, the radiographer then asked the mother if she could remove his lower clothing in preparation for the X-ray examination. James sat on the floor and began to remove his own shoes, socks, and trousers and then he got up and walked over to a cupboard in the corner of the room and opened it, holding his clothes. His mother told him to close the door and said to the radiographer 'He's a very tidy boy.'

Recognising that this gave her an opening to communicate with James, the radiographer asked him if he would like a basket to put his clothes in, just like he had seen in the waiting room. He nodded and the radiographer left the room to fetch him one. When she returned, on giving him the basket he happily folded up his clothes and placed them inside. James then pointed again to the cupboard. The radiographer walked over to the cupboard with James and opened the door, letting him place his basket on the shelf inside the cupboard; he then shut the door.

James walked back to the X-ray table with the radiographer, laid down and the examination went ahead with James happily complying with all the instructions given. Once the examination had finished, James retrieved his clothes from the cupboard and got dressed. He took the basket out of the room and placed it neatly in the pile of empty baskets ready to be reused, and then skipped off down the corridor.

Part II: 1. The Basic Training Model

Block 3. Take Home Tweaks

At this point in the training participants tend to divide into enthusiasts eager to take things forward and sceptics dubious of the practicality of VBP 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.

Read More: Below are some examples of effective tweaks to practice in diagnostic and therapeutic radiography:

- supporting patients in requesting a named nurse
- being more pro-active in feeding back to doctors
- taking time to talk through the impact of radiotherapy with patients on their first day
- ensuring patients understand why they are having imaging or treatment and give consent
- having the confidence to act as an autonomous practitioner

Anticipated barriers include:

- patients not being asked for consent
- confused patients being brought to radiography by an inexperienced nurse
- pressure of 'through put'
- feeling responsible for 'pressing' patients to accept treatment or imaging they don't want

4) Outcome Measures

As with everything else in VBP, 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 (i.e. whether participants have actually learned anything) can be assessed using methods appropriate to the aspect of values-based practice covered. See **Part III – The Resources Library, B. Collaboration Centre Website Materials, Section 1 'A Teaching and Learning Framework'** – this gives specific suggestions for each main element of VBP.

Assessment should also include feedback from participants. See **Part III – The Resources Library, A. Training Template Materials, Section 5 'Organisational Documents'** for a template feedback form.

Part II: 1. The Basic Training Model

The ultimate aim of training is better patient care where ‘better’ means as defined by the values of the individual concerned (see the stories of Mrs Jones’ knee and Hannah Walker; Part I, Section1). This follows contemporary good practice guidance as marked by the 2015 Montgomery judgment⁶ on consent (see Part I, Section 2). Again, various measures are available for assessing the different aspects of patients’ experiences of care (see for example, the Cancer Patient Experience Survey for radiotherapy <https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-patient-experience-survey/>).

Further training aims, closely related to better patient care, include:

- improved clinical outcomes
- more compassionate care
- better staff experience
- more cost-effective use of resources
- greater take-up of evidence-based guidelines
- improved ethical care (e.g. consent)
- 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.

Skills for health also have some useful tips on how to start conversations with patients: <http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download>

Part II: 2. Details of Seminar Building Block 1

As described in Part II, Section 1.3, at the heart of seminar building block 1 are two interactive exercises, the **'three words' exercise** and the **'forced choice' exercise**. Together with supporting PowerPoint presentations these exercises introduce ideas about values and VBP. The aim is to allow participants to discover for themselves the wide diversity of individual values in healthcare and hence why we need values-based as well as evidence-based practice.

This section gives:

- 1) An outline of seminar building block 1
- 2) Key learning objectives for the 'three words' exercise
- 3) Key learning objectives for the 'forced choice' exercise
- 4) Points to watch with seminar building block 1

A concluding section 5) Points to Watch about Values and How to Respond, notes some of the more challenging issues that may come up in working with values, and offers suggestions about how to respond to them.

1) An outline of seminar building block 1

Seminar building block 1 runs through two cycles of interactive exercise, plenary discussion, PowerPoint presentation and brief questions. The two cycles are summarised in Table 3 below.

Details of how the two exercises are delivered are given in Part II, Section 1.3.

The seminar outline in Table 3 below is illustrative rather than prescriptive. We hope you will find it helpful. But as with other areas of values-based training it is important to develop and adapt the materials according to your particular area of practice and the level of experience of participants.

Timing

The aim throughout should be to keep things flowing. In a two-hour seminar about 30 minutes is allocated to this introductory session. Once participants start thinking about values they naturally come up with points they want to raise, theoretical and personal (these are considered further below), see 5) Points to Watch about Values and How to Respond. 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.

Part II: 2. Details of Seminar Building Block 1

TABLE 3 – The Two Cycles of Seminar Building Block 1

Outline	Key Learning Objectives
Welcome, introductions, and plan of the seminar	
CHECK everyone has something to write with	
First interactive exercise: write down ‘three words that mean values to you’ (then compare with your neighbour)	
During the exercise CHECK with participants to see how they are getting on	
Plenary feedback of participants’ ‘three words’	Raised awareness of: <ol style="list-style-type: none"> 1) Range of values important in healthcare 2) Diversity of individual values
PowerPoint presentation	Introduction to VBP as a resource for working with diverse values in healthcare
Summarise learning points and take brief questions	
Move to second exercise	
Second interactive exercise: Choose between two treatments (then compare with your neighbour)	
During the exercise CHECK with participants to see how they are getting on	
Plenary feedback of participants’ choices	Reinforces above and adds: <ol style="list-style-type: none"> 3) Shared understanding of values as ‘what matters’ or ‘is important’ to people 4) Diverse values drive diverse choices (with the same evidence base)
PowerPoint presentation	Values-based and evidence-based practice are partners in person-centred care
Summarise learning points and take brief questions	
Move to case discussions	

Part II: 2. Details of Seminar Building Block 1

2) Key learning objectives for the 'three words' exercise

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.....

As noted in Table 3 (above) the key learning objectives from the 'three words' exercise are to raise awareness of:

Key learning objective 1 - The wide **range of values** important in healthcare

Key learning objective 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 answers. Learning objectives are then reinforced by the variety of answers participants contribute as a whole in plenary feedback.

TABLE 4 - Feedback on the Three Words Exercise

Example answers in feedback from the 'three words' exercise	
Preferences Needs Best interests	How we treat people Attitudes Principles
Respect Personal to me Difference ... diversity	Respect Compassion Dialogue
Beliefs Right/wrong What I am	Responsibility Accountability Best interests
Belief Principles Things held dear	What I <i>believe</i> What makes me tick What I won't compromise
Subjective merits Meanings Person-centred care	'Objective' Confidentiality Honesty

Part II: 2. Details of Seminar Building Block 1

Examples of feedback from the 'three words' exercise are given above in Table 4 (above).

- The **range of values** is reflected in the widely different words included: 'needs' and 'preferences' for example as well as ethical values such as 'respect' and 'honesty'.
- 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.

With these learning points in place the exercise then leads naturally into a PowerPoint introduction to **values-based practice as a resource for working with diverse individual values**.

3) Key learning objectives for the 'forced choice' exercise

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'
- Your decision - how long a period of remission would you want from treatment A to choose that treatment rather than go for a 50:50 chance of 'kill or cure' from treatment B?

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:

Key learning objective 3 - A shared understanding of values as 'what matters' or 'is important' to people

Key learning objective 4 - Understanding that diverse individual values drive diverse individual choices, even with the same evidence base

These again start to become apparent as participants compare notes. They usually find that they have come up with different periods of remission, and in plenary feedback they realise that this is true of the group as a whole.

Part II: 2. Details of Seminar Building Block 1

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 reasons for their choices, they come to see that the range of their answers reflects the diversity of their individual values.

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 have for choosing as they did are all about their individual values. But it is worth pressing groups to recognise this for themselves, rather than just explaining it. In getting to 'Ah, yes, it's my values' phrases, for example "finishing my PhD is what's important to me" (from the person who wanted an assured twelve months) or "what matters to me is my children" (from the person who would not accept a remission period of less than fifty years before choosing treatment B).

The discussion thus delivers both learning objectives in one:

- From the way participants talk about their reasons, they come to a shared understanding of values as 'what matters' or 'is important' to people (key learning objective 3)
- From seeing how different the things are that matter, or are important to each other, they see that it is their individually diverse values that drive their individually diverse choices (key learning objective 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 to make 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? My partner went on to explain his answer, which I fully understand and agree with, and I realised that unless we ask, we will never know what matters to each other."

PowerPoint continued: values-based practice and evidence-based practice are partners in clinical decision-making

The surprising diversity of what matters to people (i.e. people's values) is why, as the PowerPoint presentation now goes on to spell out, VBP is important for clinical decision-making as a partner to evidence-based practice.

Part II: 2. Details of Seminar Building Block 1

Evidence-based medicine says this too

The message about partnership between values- and evidence-based practice is reinforced in the PowerPoint by the fact that evidence-based medicine itself was originally formulated as bringing together evidence with values in clinical decision-making. David Sackett (as the first Director of Oxford's Centre for Evidence-Based Medicine) actually defined evidence-based medicine as "combining best research evidence with clinical experience and patients' values". See Evidence-based Guidelines in Part I, Section 2.

Consistent with this message from the two exercises, Sackett defined values as "the unique preferences, concerns and expectations each patient brings to a clinical encounter ...", and that is important as the basis of a "**diagnostic and therapeutic alliance** that optimizes **clinical objective and quality of life**" (emphases added).

Evidence-based practice, this part of the presentation thus concludes, is needed if clinical decision-making is to reflect best evidence. But values-based practice is needed if best evidence is to be linked up appropriately with the unique values of an individual patient. This is why VBP and evidence-based practice are partners in the delivery of person-centred care.

Read More: For an example of the PowerPoint presentation see **Part III – The Resources Library, A. Training Template Materials, Section 4.**

4) Points to watch with seminar building block 1

There are important points to watch at key stages in running this first part of the seminar:

- i) In starting both exercises
- ii) In starting the 'forced choice' exercise in particular
- iii) In taking plenary feedback

i) 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!

Part II: 2. Details of Seminar Building Block 1

- **The order is important**

The effectiveness of the exercises depends on participants finding out for themselves that everyone comes up with different answers (different triplets of words in Exercise 1 and different 'required periods of remission' in Exercise 2). So it is worth emphasising that participants should write down their own answers before comparing notes to see what others have written.

As indicated in the seminar outline (Table 3,) it is helpful to walk around after setting each exercise to see how things are going. Some participants will find these exercises difficult (see point 5 below, Points to watch about values and how to respond). 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."

With the 'forced choice' exercise it is usually better not to push participants since their reluctance may reflect personal associations with the choice they are being asked to make.

ii) **Further points to watch in starting the 'forced choice' exercise**

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 chance offered by 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 PowerPoint 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.

Part II: 2. Details of Seminar Building Block 1

It's **your** decision....

“How long a period of remission would I want from treatment A to choose that treatment rather than go for a 50:50 chance of ‘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

iii) **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. PowerPoint 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!

Part II: 2. Details of Seminar Building Block 1

5) 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.

Read More: For a case discussion illustrating the compatibility of values-based practice with strongly held personal beliefs (given mutual respect), see chapter 12 of *Essential Values-based Practice*.²

Part III – The Resources Library

This section provides a series of resources that may be helpful in planning and delivering training in values-based practice for clinical care.

- 1) How to use the Resources Library
- 2) Descriptive index and section links
 - A. Training Template Materials
 - B. Collaborating Centre Website Materials

Acknowledgements

Materials in this Resources Library have been generously contributed by Faculty Partners and represent our combined experiences of developing values-based practice in a number of areas of healthcare.

Part III: 1. How to use the Resources Library

The materials in this Resources Library are linked to the Collaborating Centre website. The descriptive index given below provides direct links to the contents of each section.

A. Training Template Materials

- 1) Planning a seminar: a step-by-step guide
- 2) Example seminar outlines
- 3) Example clinical cases
- 4) Other seminar resources (e.g., PowerPoint presentations, handouts)
- 5) Organisational documents

The resources in these sections are free to view and can be downloaded in PDF format by accredited Faculty Partners (see below, Becoming a Faculty Partner).

B. Collaborating Centre Website Materials

- 1) A Teaching and Learning Framework
- 2) Training Manuals
- 3) Policy and Practice Guidance
- 4) Search Strategies
- 5) Reading Guide

These resources are available to view on the Collaborating Centre website. Most are available as full-text downloads.

Illustrative not prescriptive

As with other sections of the Handbook the materials included here are illustrative rather than prescriptive. We hope they will be helpful as a starting point. But the idea is that they should be developed and adapted to meet the particular circumstances presented by different groups of trainees in distinct areas of clinical care.

Becoming a Faculty Partner

If you are interested in becoming a Faculty Partner please see **Introduction, Section 3, 'Accreditation and Shared Learning'**.

Part III: 2. Descriptive index and section links

The materials in the Resources Library are divided into:

- A. Training Template Materials
- B. Collaborating Centre Website Materials

This descriptive index lists the resources available and provides direct links to both locations.

A. Training Template Materials

- 1) Planning a seminar: a step-by-step guide
- 2) Example seminar outlines
- 3) Example clinical cases
- 4) Other seminar resources
- 5) Organisational documents

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

1) Planning a seminar: a step-by-step guide

This section sets out the key steps we have found helpful for organising seminars in values-based surgical care for clinical teams. Similar steps may be helpful for seminars with other groups in other clinical areas. The Collaborating Centre offers support with organising and running seminars: see **Introduction, Section 3 'Accreditation and Shared Learning'** or contact us via the Collaborating Centre website ([Contact us](#)).

Read More: To view this resource, please go to the [valuesbasedpractice.org Resources Library](#) using the following link [Planning a seminar: a step-by-step guide](#)

2) Example seminar outlines

Example seminar outlines are given in this section for:

- radiographers
- student radiographers
- assistant practitioners
- radiology nurses
- radiologists
- oncologists

The seminar outlines should be read in conjunction with **Part II – The Training Template**.

Read More: To view this resource, please go to the [valuesbasedpractice.org Resources Library](#) using the following link [Example seminar outlines](#)

Part III: 2. Descriptive index and section links

3) Example clinical cases

Example cases are given in this section for:

- radiographers
- student radiographers
- assistant practitioners
- radiology nurses
- radiologists
- oncologists

These cases given are for illustrative purposes only. Case material should always reflect participants' level of experience and area of work (see **Part II – The Training Template, Section 1.3 'Three Seminar building blocks'**).

Read More: To view further clinical case examples, please go to the [valuesbasedpractice.org Resources Library](https://valuesbasedpractice.org) using the following link [Example clinical cases](#)

4) Other seminar resources

This section includes materials helpful in preparing a seminar. As with other materials in the Resources Library these are illustrative only and should be adapted appropriately for a given group or teaching context.

Read More: To view these resources, please go to the [valuesbasedpractice.org Resources Library](https://valuesbasedpractice.org) using the following links:

[PowerPoints](#)

[Flip chart responses to exercises](#)

[Handouts](#)

[Suggested reading](#)

5) Other seminar resources

This section gives exemplar documents for organising and running seminars in values-based practice.

Read More: To view these resources, please go to the [valuesbasedpractice.org Resources Library](https://valuesbasedpractice.org) using the following links:

[Invitation](#)

[Feedback form](#)

[Certificate of attendance](#)

Part III: 2. Descriptive index and section links

B. Collaborating Centre Website Materials

- 1) A Teaching And Learning Framework
- 2) Training Manuals
- 3) Policy and Practice Guidance
- 4) Search Strategies
- 5) Reading Guide

The resources in this section of the Resources Library are available to view on the Collaborating Centre website. Most are available as full-text downloads.

1) A Teaching and Learning Framework

This Teaching and Learning Framework sets out the knowledge, skills and behaviours needed for each of the ten main process elements of values-based practice and suggests appropriate assessment measures (e.g., multiple choice, significant event analysis, reflective portfolio, written questions, etc.).

The Framework was developed by Professor Ed Peile, who is a founder Management Team member of the Collaborating Centre for Values-based Practice. See valuesbasedpractice.org using the following link [Who are We?/ Management Team](#)

The Framework was published originally as Appendix B of Essential Values-based Practice.²

Read More: To view the framework please go to valuesbasedpractice.org using the following link [A Teaching and Learning Framework](#)

2) Training Manuals

The Collaborating Centre website hosts PDFs of a number of training manuals for values-based practice. Although developed mainly for mental health and other areas of primary care they are readily adaptable to other contexts.

- **‘Whose Values?’ A workbook for values-based practice in mental health care.** Woodbridge, K., and Fulford, K.W.M. (2004) London: The Sainsbury Centre for Mental Health.

As the first training manual for values-based practice, ‘Whose Values?’ provides a series of practical and case-based exercises exploring each of the main process elements of values-based practice.

Translated into Brazilian-Portuguese as *Valores de Quem?* Brazilian-Portuguese Translation of ‘Whose Values?’ by Arthur Maciel.

- **Who Needs Values? Approaching Values-based Practice in Medical Education – Instructors Manual** Chevinsky, J., Fulford, KWM (Bill), Peile, E., and Monroe, A., (2015)

‘Who Needs Values?’ is based on work that Jennifer Chevinsky completed during a six-week medical student placement with Bill Fulford and Ed Peile. It offers a longitudinal curriculum highlighting the connection between values-based and evidence-based practice, and other important topics such as cultural competency, bioethics, medical anthropology, public health, and interdisciplinary teamwork.

Part III: 2. Descriptive index and section links

- **Workbook to Support Implementation of the Mental Health Act 1983 as Amended by the Mental Health Act 2007.** Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE) (2008) London: Department of Health.

This is the foundation module for a suite of materials produced by the Department of Health in the UK to support implementation of the then recently launched Mental Health Act 2007. It offers a values-based approach to involuntary treatment in mental health, based on balanced decision-making within a framework of shared Guiding Principles.

Read More: For more about these training manuals and to download free copies, please go to valuesbasedpractice.org using the following link [Full Text Downloads](#)

3) Policy and Practice Guidance

Policy and practice guidance based on combining values-based with evidence-based approaches has been developed for a number of areas. The ‘Workbook to Support Implementation of the Mental Health Act 1983...’ (above) was produced originally as practice guidance. Others hosted by the Collaborating Centre website include:

- **3 Keys to a Shared Approach in Mental Health Assessment.** National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (2008) London: Department of Health.

The 3 Keys program was co-led by Laurie Bryant, Lu Duhig and Bill Fulford, the Department Leads at the time, respectively, for Service User (Laurie) and Carer (Lu) Perspectives, and for Values-based Practice (Bill), and remains the focus of work by the Collaborating Centre Partner, the Bristol Co-Production Group.

- **Values-based Practice Decision-making Protocol – User Guide** Woo Yan-wah, R., (2014).

The Decision-making Protocol provides a comprehensive explanation of a 16-step process of values-based decision-making in forensic social work with a case example and a procedural guide.

It was produced by Collaborating Centre partner Reuben Woo and is based on his work at the Society of Rehabilitation and Crime Prevention, Hong Kong.

- **The National Framework of Values for Mental Health.** National Institute for Mental Health England (2004) London: Department of Health.

Although produced in the context of a specific series of policy and practice initiatives, this Framework and the process by which it was produced remain helpful exemplars of policy developments in values-based practice.

Read More: For more about these resources and to download free copies, please go to valuesbasedpractice.org using the following link [Full Text Downloads](#)

Part III: 2. Descriptive index and section links

4) Search Strategies

Knowledge of values is an important process element of values-based practice (see Introduction, Section 1). But searching for values-related literature is difficult because relevant search terms are not sufficiently specific (if you search for 'value', you get millions of 'hits', for example, "the values of haemoglobin"!).

Resources to support literature searching for values include:

- **VaST Values Search Tools: a manual for searching electronic databases for health-related values.** Petrova, M., (2012)

Developed by Mila Petrova and colleagues at Warwick Medical School the VaST manual includes a short search string published separately as: Petrova, M., Sutcliffe, P., Fulford, K. W. M., and Dale, J. (2011) *Search terms and a validated brief search filter to retrieve publications on health-related values in Medline: a word frequency analysis study*. Journal of the American Medical Informatics Association, DOI: <https://doi.org/10.1136/amiajnl-2011-000243>

Read More: To access this resource, please go to valuesbasedpractice.org using the following link [Full Text Downloads](#)

- **A Smoking Enigma: getting and not getting the knowledge.** Ch 6, pps 65 – 82 in Fulford, K.W.M., Peile, E., and Carroll, H *Essentials of Values-based Practice: clinical stories linking science with people* Cambridge: Cambridge University Press.

This chapter of 'Essential Values-based Practice' provides a practical step-by-step guide to searching for values-related literature running from a quick 'google' search through to more sophisticated methods (including Petrova's search string).

- **Search Protocol for Values-based Service Developments**

Fran Whitaker developed a search protocol for papers reporting evaluations of values-based service development projects in the context of her research for the Royal College of Psychiatrists' Commission for Values-based Child and Adolescent Mental Health Services.

Read More: You can access Fran Whitaker's search protocol via valuesbasedpractice.org using the following link [Values-Based Commissioning and Service Development in Child and Adolescent Mental Health: a Systematic Review](#)

Part III: 2. Descriptive index and section links

5) Reading Guide

The Collaborating Centre website includes a detailed annotated Reading Guide in the section 'More about VBP'.

The Reading Guide covers the theory and practice of VBP including its philosophical and empirical origins and contemporary developments in policy, training and clinical practice.

Read More: To explore the Reading Guide please go to **valuesbasedpractice.org** using the following link [Reading Guide](#)

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