Discussing values in paramedic practice

Antonia L. Cook, Matt Capsey, Chris Jones, Tom Davidson, Georgette Eaton

Journal of Paramedic Practice 15/4 April 2023

Abstract: A case-based discussion around values-based practice illustrates how the elements of values-based practice can be used to: navigate a challenging situation in practice; examine how it intersects with legal considerations; and offer both opportunities and challenges to clinicians.

Storytelling has long been recognised as important to paramedics. This helps to build professional identity and identify correct practice, and can be used as a safe way of exploring professional opinions (Tangherlini, 2000; Furness et al, 2016). A strength of stories is that they allow both the storyteller and the listener to place themselves in the narrative and consider the question, 'What would I do?'. This positioning of individuals, both patients and clinicians, as an important part of delivering care is a key element of values-based practice (Fulford and Carroll, 2012).

Values by their very nature differ between individuals but, at times, it is assumed that professional values are shared universally (Eaton, 2019). Values may not be routinely discussed and may be discovered only when faced by a difficult or challenging situation.

Often situations are difficult because there is not a clear way to apply pure evidence-based practice. Values-based practice complements evidence-based practice by allowing the human element of practice to be presented and valued (Fulford and Carroll, 2012). Stories lend themselves to exploring this human element.

In this article, the authors present values-based practice and use a story to illustrate how some of the elements of the approach can be used to: navigate a challenging situation in practice; examine how it intersects with legal considerations; and offer both opportunities and challenges to the clinician. This story is fictional but based on experience, and confidentiality has been maintained.

The story

This case considers a 90-year-old woman presenting with new lethargy and left-sided chest/flank pain. The patient described a multi-week history of left-sided axial rib and flank pain, a 48-hour history of worsening peripheral pitting oedema in her legs and positional shortness of breath. Her past medical history included breast cancer with associated mastectomy, stage 3 chronic kidney disease and a urinary catheter in situ.

Shortly after the paramedic's arrival, the patient's daughters requested to speak to the paramedic in a separate room. They informed the paramedic that following admission to hospital 3 months earlier for pneumonia and hospital-acquired COVID-19, a relapse in the patient's breast cancer had been identified. This had been diagnosed as terminal with liver and bony metastasis. The patient had been discharged from hospital 1 week prior. The daughters said the patient was unaware of the return of her cancer or of the terminal diagnosis and they would prefer it to remain that way for their

mother's mental health. They added that palliative care services were not yet involved because of the short time since diagnosis but local hospice support was being arranged.

On examination, it was noted that the patient had upper lobe fremitus, with good movement and depth. She was tachycardic and had a NEWS2 score of 2. Her seating posture was poor, and she was unable to hold herself up in the seat, likely because of spinal degeneration caused by the cancer.

The family stated that the hospital team had not informed the patient of her diagnosis in discussion with the family as they felt it would be bad for the her mental health and risk a relapse of her delirium and confusion, which had been factors during the hospital admission.

The paramedic discussed with the daughters that they advised the patient should attend hospital for further investigation due to the possibility of pulmonary embolism, heart failure, pneumonia and untreated cancer-related symptoms. The family highlighted the patient's unwillingness and likely refusal to return to hospital. They, again, asked that the patient not be informed about her cancer and asked if the crew could omit this as a potential cause of the pain and recent decline.

The patient did not have a lasting power of attorney for health and welfare in place and was assessed as having mental capacity at the point of attendance.

The paramedic highlighted to family the ethical, moral and legal concerns they had with withholding information from the patient and the ability of the patient to make an informed decision about her own care without all of the information pertaining to herself. The paramedic also felt it was not their place to break this challenging and emotionally fraught news as they did not have all of the information surrounding the diagnosis or many of the answers to questions that would likely arise.

The paramedic worked in conjunction with the family to ensure they understood the need for the patient to be informed. Following this, the paramedic contacted the patient's GP to inform them of the situation; the GP was not aware of the new diagnosis but understood the complexity of the situation and the need for the patient to be involved.

The GP advised that if the patient did not wish to attend hospital for the day's presentation, then any diagnosis would be difficult as community blood tests and diagnostic tools were likely to be inconclusive or display unreliable results because of the complexities of the cancer. They also agreed that the paramedic was not best placed to break the news and that the conversation required a multidisciplinary approach and planning. The GP was due to attend a multidisciplinary team meeting with the local hospice in the morning to discuss the patient and her needs.

With this in mind, the paramedic contacted the local hospice to inform them of the current situation to support them to enable preparation and information gathering from their side for the multidisciplinary team meeting.

The local hospice nurse agreed with the GP that the patient required an urgent discussion to break the news, but that the paramedic was not the best-placed person to do this on this occasion. The nurse also provided a number that any further ambulance crews could contact if they attended before palliative care plans had been put in place, and this was to be called before any transportation to a care facility.

The patient was informed of the potential noncancerous causes of the day's presentations and led on to a holistic conversation and care journey options. The patient valued remaining at home with her daughters and receiving any treatment at home. She did not want to attend hospital but wished to be comfortable at home.

The paramedic raised the idea of a lasting power of attorney and advanced care plan with the patient for her to consider moving forwards, so she could explore, understand and record her wishes while she was able to do so. The paramedic ensured the patient was left in a comfortable state in her own home with robust written advice on what to do if symptoms worsened and a plan in place to move this difficult situation forward.

Values

Despite its ubiquity, 'of all the widely invoked concepts, few are as difficult to specify as the concept of values' (Almond and Wilson, 1988: 1). The origin of values is a contentious subject, and values are often wrongly conflated with virtues, morality and logic; they are similar only in that they can all be consciously and subconsciously explored by an individual.

Their longevity means that values have come to be defined from a range of perspectives, as being the 'standards by which our actions are selected' or as a 'belief upon which man acts by preference' (Allport, 1961: 454). Both these definitions focus on an action and imply a degree of choice.

Values are also commonly viewed as moral principles or 'guidelines for individual, societal actions and… the regard one person has for another—their integrity, trustworthiness and moral character' (Thomas et al, 2010: 16). The Oxford English Dictionary defines 'value' as 'to consider of worth or importance; to rate highly; to esteem; to set store by' (2023). This appears to be the most widely accepted definition, with values associated with some 'good' such as truth, according to Halstead (1996), or as experiences or activities that serve to encourage human wellbeing (Beck, 1990).

It is this action-guiding feature of values that makes them a fundamental element alongside evidence within all clinical decision-making, as Sackett's original definition outlines (Sackett et al, 2000). However, unlike published evidence, values are not always explicit and values-based practice is a twin framework to evidence-based practice.

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

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

Legal framework

It is clear from the narrative that the patient's daughters had influenced the decision about choosing not to tell their mother that she was now terminally ill. This posed an ethical dilemma for the paramedic, who was now in a 'catch-22' position of trying to obtain informed consent to various treatment options without being able to fully inform the patient about the decisions she was being asked to make. The patient's daughters had determined that knowledge of the relapse of cancer could affect their mother's mental health, and cause a potential relapse of her delirium. The daughters' wishes were to protect their mother from this and 'spend the remaining time left with her together'.

Although well meaning, these views are based on a paternalistic approach that the daughters had adopted towards their mother.

A paternalistic approach over patients with capacity was incompatible with their right to make autonomous decisions, as Dame Elizabeth Butler-Sloss highlighted in the case of Ms B (Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam)). Although Ms B's case involved the paternalistic approach of medical professionals, not family members, she was clear that, in patients with capacity, respect for their autonomy was paramount and 'a seriously disabled patient has the same rights as the fit person to respect for personal autonomy'.

Autonomy was also put at the forefront of the decision in the Montgomery case in the UK Supreme ourt (Montgomery v Lanarkshire Health Board [2015] UKSC 11). The Montgomery case centred on informed consent to medical treatment and what information about risks of proposed treatments medical professionals are required to provide to ensure the patient is fully informed. Previously, it had been held that medical professionals only needed to explain risks they felt were relevant to the patient.

This was the Bolam standard, where 'a medical professional is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art' (Bolam v Friern Hospital Management Committee [1957] 1 WLR 583). In other words, the doctor (or the paramedic) would only have a duty to explain risks that the professional group thought were relevant to tell the patient about.

Montgomery, however, departed from the Bolam standard, with Lords Kerr and Reed explaining that, 'the doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments'.

Therefore, the default standard for consent for treatment or proposed courses of action to be considered valid or informed is now that the health professional must discuss all material risks with the patient.

In the narrative presented here, the paramedic would be unable to discuss any proposed risks with the patient, as she was unaware of the true extent of her condition, thereby unable to effectively make an autonomous decision.

Indeed, in the case of Tracey (R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822), the court found that not consulting a capacitous patient about medical decisions may result in a breach of the patient's fundamental human rights. Doctors in the Tracey case had instigated a do not attempt cardiopulmonary resuscitation order without discussion with the patient or her family and the court determined this had interfered with the patient's right to respect to a private and family life under article 8 of the Human Rights Act 1998. Lord Justice Ryder in

his judgment further determined that consultation with the patient was critical to high-quality care and that a failure to consult would be an affront to her dignity.

The Tracey case also addressed the concerns that the daughters had in this case regarding the potential for a deterioration in their mother's condition following the discussion of bad news. Lord Justice Ryder explained that 'convincing reasons' were required for a clinician not to discuss serious matters with a patient and this may arise when a 'clinician considers that it would likely cause the patient to suffer physical or psychological harm'. In this case, a paramedic with little or no previous knowledge of the patient may struggle to determine if this was likely; therefore, the outcome of a multidisciplinary meeting the following day between those involved in the patient's care was a good outcome regarding determining the future course of action.

Opportunities and challenges

Within this scenario, there are a number of conflicting values between the relatives and the patient, and between the clinician and the views of the relatives. Often, clinicians encounter situations within clinical practice where there are conflicting values and providing a solution that accommodates all can be challenging. Values-based practice provides a number of opportunities to increase the quality of patient care by ensuring it is patient centred.

Paramedics interact with a broad range of society and deliver healthcare in a variety of settings alongside a number of other health professionals. This exposes paramedics to a wide range of personal, professional and cultural values on a day-to-day basis. Clinicians can use values-based practice to help ensure they practise inclusively. Values-based practice holds mutual respect for differences of values as a key premise and, if clinicians adopt this approach, then discriminatory practice may be eliminated (Fulford and Carroll, 2012).

There is a risk within patient interactions that practitioners focus purely on the medical components of clinical encounters and do not incorporate the patient into the clinical decision-making process.

This risk was also identified when evidence-based practice was originally adopted. Early definitions of evidence-based practice were the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision-making (Sackett et al, 2000). However, a focus on using the best evidence to solve patient health problems oversimplified the complexity of clinical judgement and failed to acknowledge contextual influences such as the patient's status or the organisational resources available that change constantly and are different in every situation (Rycroft-Malone and Bucknall, 2010).

Values-based practice offers the opportunity to create an authentic patient interaction that allows clinicians and patients to interact meaningfully. Values-based practice focuses on the process of patient interaction rather than the outcome (Fulford and Carroll, 2012). This approach will result in deeper patient interaction and lead to balanced decisions being made between patients, carers and clinicians.

Clinicians may normally identify obvious clashes in values. This could be a patient not wanting to receive treatment because of religious beliefs or refusing to attend hospital when advised. It is the more subtle values that can be missed within a patient interaction. Fulford and Carroll (2012) explain that values are everywhere in clinical encounters. The risk of not applying values-based practice is that clinicians could miss important values as they are not overt.

Values-based practice is in part about making explicit the range and variety of values bearing on the clinical consultation and managing them more effectively (Fulford and Carroll, 2012). This conscious acknowledgement of values and true incorporation into decision-making may reduce the risk of not providing person-centred care.

Summary

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

The story in this article aims to make this point. Some paramedics in this situation may have simply transferred the patient to hospital rather than having difficult conversations with the daughters and other health professionals. This story was founded on a premise of mutual respect, and that is the basis of how values-based practice may be implemented. The paramedic had the skills to pick this up and explore its implications.

How do paramedics 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 the skills and positionality of individual practitioners are important in how values-based practice is implemented. However, learning and experience of what works can be shared through telling stories. Sustainable implementation of this, however, depends on a whole-system approach incorporating other elements of values-based practice. Paramedics work across many different settings, both clinical and non-clinical—yet the ethos of values-based practice is pertinent to them all. Raised awareness of values is essential to contemporary person-centred care.

Key points

Values-based practice is a twin framework to evidence-based practice

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

Values-based practice focuses on the process of patient interaction rather than the outcome

The Montgomery case focuses on the importance of providing information about risks of proposed treatments to patients, ensuring that the patient's decisions are based on fully informed principles

The conscious acknowledgement of values and their true incorporation into decision-making will reduce the risk of not providing person-centre care

CPD Reflection Questions

What are your values? How may these differ from your patients' and their families?

Reflect on your practice. Do you always make a shared decision with your patients?

Do you ever influence your patients' decisions with your values?