

Values-based practice in primary care: easing the tensions between individual values, ethical principles and best evidence

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ABSTRACT

Background

The provision of health care is inseparable from universal values such as caring, helping and compassion. Consideration for individual values, particularly those of the patient, has also been increasing. However, such consideration is difficult within the context of modern health care, where complex and conflicting values are often in play. This is particularly so when a patient's values seem to be at odds with evidence-based practice or widely shared ethical principles, or when a health professional's personal values may compromise the care provided.

Suggested new framework

Values-based practice, a framework developed originally in the domain of mental health, maintains that values are pervasive and powerful parameters influencing decisions about health, clinical practice and research, and that their impact is often underestimated. Although it shares starting points with other approaches to values, it suggests that our current approaches lead us to ignore some important manifestations of values at both the general level, as relevant in legal, policy and research contexts, as well as at the individual level, as relevant in clinical practice. Drawing on ideas from philosophy, values-based practice significantly extends the range of phenomena that may be regarded as value-laden. It suggests that one of the reasons for overlooking values is that they are presumed to be shared when not apparently conflicting. Values-based practice is an approach to supporting clinical decision-making, which provides practical skills and tools for eliciting individual values and negotiating these with respect to best available evidence.

Keywords

delivery of health care; ethics; evidence-based medicine, trends; models, theoretical; professional-patient relations; social values.

INTRODUCTION

Modern health care is often defined in terms of four precepts: that it should be evidence-based; patient-centred and inclusive of carers and the community; continuous and coordinated across settings; and ethically sound and regulated.

This paper will suggest that these precepts may be implemented more effectively if values, coming in many more forms and at many more levels than often recognised, were better identified and more skillfully negotiated. It will discuss how the values-based practice framework, a new approach to incorporating values in clinical decision making, can contribute to such ends. The niche for a new approach to values will be sought by outlining how the values-based practice framework relates to other approaches to values and to evidence-based medicine. The paper will also consider what changes to practice, education and research may be required so that primary care and health care in general can become more individual values-based.

Values-based practice is one of a number of new approaches to supporting clinical decision making where complex and sometimes conflicting values are in play.^{1,2} Derived from work in analytic philosophy,³ it provides a clinical skills-based approach to linking the generalised scientific knowledge of evidence-based

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How this fits in

A number of disciplines and approaches have addressed values in health care, with bioethics and research informed by the social and human sciences contributing the most to how values are handled in clinical practice. However, such approaches often face difficulties of burdensome regulation or limited applicability in clinical decision making. Values-based practice is a new framework which emphasises the centrality of values in clinical decision making; the diversity of values, which may remain unnoticed if they are presumed shared; and the importance of health professionals' developing skills to identify and negotiate values. It is suggested that since primary care is an area of significant diversity of values, values-based practice may have particular relevance there and the importance is discussed of developing appropriate training and research.

practice to the particular values — the needs, wishes and expectations — that individual patients bring to the clinical encounter.⁴ The principles of evidence-based practice and values-based practice thus work together as a basis of shared decision making between practitioners, their patients and families.⁵ Values-based practice is also complementary to ethics: ethical principles, together with medical law, provide a framework of shared values, such as 'best interests' and 'confidentiality'; values-based practice provides an approach for reaching balanced decisions where framework values are in conflict.⁶

Values-based practice is already the basis of a number of national training^{7,8} and policy initiatives^{9,10} within mental health. Its broader relevance to key current policies within the NHS is being more generally recognised,^{11,12} and as a training tool it is now being extended to other areas of health care — see, for example, the Royal College of General Practitioners' curriculum statement on ethics and values-based medicine.¹³

VALUES ARE ALL AROUND, BUT OFTEN UNRECOGNISED

It is practical to ignore shared values, but the shared values base in health care is diminishing

A central concept of values-based practice is that all decisions are informed by both facts and values.^{4,14} However, when sets of values are shared, their presence may remain unnoticed⁶ — if they are constant parameters in the decision-making process, the lack of recognition for them will not affect the outcome. For example, when presented with a pulsating open wound, we decide to suture it not only because this stops the blood from gushing out, but also because we have made certain value judgements — that human life is precious and that it may be in danger. Such value judgements only act in the background, as there is almost universal agreement about them.

In modern health care, this universal agreement about values is diminishing. Scientific advances have increased the range of available options, with different options accommodating different values.⁶ Society has become both more heterogeneous and more open to different forms of living with the diverse values they embody, and health care has come to reflect this. The new patient-consumer has become more knowledgeable, powerful and explicit about his or her values. Clinical focus has also changed — there has been a shift of emphasis from treatment to prevention, from hospital to the community, from the relative uniformity of the in-patient ward to the huge variety of our lifestyle and everyday practices. Such changes limit the range of shared values that can be taken for granted when making decisions about health.

It is easy to notice values when they are in clear conflict. It is often assumed that values are shared when they are in no apparent conflict

Values demand attention when they are at odds with other values, as choosing between conflicting values may produce entirely different, sometimes mutually exclusive, decisions and consequences. In the open wound example given before, the relevant values are widely shared, but this may change if the situation is further defined, for instance, by a need for blood transfusion. Blood transfusions are unacceptable to members of certain religious groups and such individuals may place a higher value on a person's identity than on the maintenance of life. In this situation the relevant, already divergent, values have become salient and practically important.

It is usually when values come into clear conflict that they are detected. This is often the case when we are faced with bioethical dilemmas or distinct ethnic and cultural differences, and bioethics and health care research informed by the social sciences are well equipped to elicit and discuss such phenomena. However, when the differences of values are less salient or do not characterise some predefined groups of people, we are likely to miss them — in practice, policy and research. For example, cultural differences in body size preference are widely discussed and many practitioners recognise such values as potential barriers to conveying weight-loss advice. In this case, the difference in values is immediately taken into account. When there is a certain level at which values are shared, however, the differences at other levels may become obscured.

If a patient and their health professional agree about the importance of weight loss, they may fail to notice how differently they perceive the best way to achieve it — the former may believe that there is a

problem with her metabolism and expect tests and medication, while the latter may recommend lifestyle changes. Presuming that more values are shared than actually are may prevent shared decision making or bring about unexpected decisions and outcomes.

Values, processes of evaluation and values in science

We tend to think of values primarily as principles, standards, virtues and social norms 'owned' by individuals, groups and societies, as relatively fixed and stable, as inputs in and outputs from the decision-making process. The related dynamic aspect, however — of assigning value, of making and changing one's evaluations — is equally important in making health-related decisions. This aspect is exemplified by questions, such as how people come to perceive risk; what influences these perceptions and how these change; how different individuals assign importance and salience to symptoms; and how they come to perceive difficulties as barriers or otherwise. Such processes are not traditionally seen as having a common denominator. Within the values-based practice framework this is their evaluative nature.

There is one further manifestation of values that has tended to attract only minimal attention. It concerns the evaluative aspects of scientific and professional judgements. Values-based practice takes up the view that scientific knowledge cannot be strictly factual, but that this does not make it any less scientific. It cannot be completely value-free because value judgements are indispensable to scientific practices such as making assumptions, setting significance thresholds, or balancing between the advantages and disadvantages of different methodologies.

This has implications for research and our attitude to evidence, as well as for interprofessional collaboration in health care. Each of the subdisciplines of health care relies on some basic, value-laden, principles and assumptions that are shared only partly by other subdisciplines in the field. The GPs' models of illness and patient care are different to the nurses' not only in their factual information, but also in such basic principles and assumptions. An obvious example of this is the different importance doctors and nurses tend to ascribe to the physical determinants of health and illness as compared to the psychosocial ones. Thinking of such differences in terms of values, rather than in terms of rightness, is possibly a necessary starting point for interprofessional collaboration.

Values-based practice and related frameworks

The values-based practice framework is certainly not the first to point to the importance of values in health

Box 1. Ten principles of values-based practice.¹⁴

- ▶ Values-based practice and evidence-based practice
 1. All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis
 2. We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic
 3. Scientific progress, in opening up choices, is increasingly bringing the full diversity of human values into play in all areas of health care
- ▶ Values-based practice and models of service delivery
 4. The 'first call' for information in values-based practice is the perspective of the patient or patient group concerned in a given decision
 5. In values-based practice, conflicts of values are resolved primarily not by reference to a rule prescribing a 'right' outcome, but by processes designed to support a balance of legitimately different perspectives
- ▶ Values-based practice and clinical practice skills
 6. Careful attention to language use in a given context is one of a range of powerful methods for raising awareness of values and of differences of values
 7. A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people's values
 8. Ethical reasoning is employed in values-based practice primarily to explore differences of values, not, as in quasi-legal bioethics, to determine 'what is right'
 9. Communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in values-based practice
- ▶ Values-based practice and shared decision making
 10. Values-based practice, although involving a partnership with ethicists and lawyers (equivalent to the partnership with scientists in evidence-based practice), puts decision making back where it belongs, with users and providers at the clinical coalface

care — this has received attention within a number of disciplines and theoretical systems. Most of its principles^{4,14} (Box 1) will be readily recognised as shared by several disciplinary fields, notably bioethics, health psychology, medical sociology and the medical humanities, as well as by a number of approaches to practice, such as patient-centredness, community-oriented provision of services, spirituality approaches and narrative-based medicine. Fields of inquiry in which values are less central, such as evidence-based medicine, decision theory and health economics, nonetheless acknowledge their importance. In what follows, we will attempt to outline how values-based practice differs to other approaches to values and how it relates to evidence-based medicine.

Values-based practice and bioethics — how universal can values be?

Bioethics is currently the main approach used for handling the complexity of values in clinical practice. It aspires to determine the right course of action in complex health-related situations, often through reasoning about how high-level principles, such as

non-maleficence, beneficence, autonomy, justice and 'the right to know' are manifested in a specific situation and what the potential threats to them are. As protection of the patient and research participant has been, for historical reasons, bioethics' main concern, much has been done in developing rules, regulations and codes of practice aimed to assure it.⁶

These are indispensable endeavours, but in certain respects the scope of mainstream bioethics may be too limited. Scientific advances and societal changes have resulted in the shared values base becoming narrowed to the extent that even general, *prima facie* principles may need a fresh analysis. The principle of autonomy, for instance, strongly cherished by western cultures, does not have a comparable priority in more traditional or collectivist societies. With the increasing options provided by scientific progress, what beneficence and non-maleficence involve also becomes debatable: what is good for some cultures, groups and individuals may be unacceptable or harmful to others. With the advancement of diagnostic technologies, which may soon be able to pinpoint the slightest bodily dysfunction, the right to know may turn into a burden for some people. They may choose to relinquish it in order to enjoy a better quality of life.

Compared to mainstream bioethics, the framework of values-based practice is a less prescriptive and more local approach. It aims to introduce a greater variability of viewpoints and greater recognition for individually specific values. It suggests that a move away is needed from searching for universal sets of values to accommodating more particular sets of these, some held by certain cultures, societies or smaller groups, others held only by certain individuals.

For example, if screening for dementia is approached from a bioethical perspective, a 'right to know' line of argumentation may suggest that all patients at risk be actively screened and advised of detected degenerative processes. From a values-based practice perspective however, what is rational in view of a certain principle, or even preferred by most patients, is irrelevant in the case of an individual patient. It may still be in the patient's best interests to act on a different principle or set of values.

The individual values orientation of values-based practice makes for two further differences from mainstream bioethics. One is that bioethical reasoning is seen as a tool for defining a situation rather than for reaching a right answer. The other is that the development of skills in facilitating processes of negotiation of values is considered a priority, much more so than the development of ever more articulate rules, regulations and recommendations. It is thus a less legalistic approach than bioethics.⁶

Values-based practice and the social and human sciences

Unlike bioethics, values-based practice is interested not only in moral values, but also in differences in perspective, preference, priority, point of view — a respect for differences in individual, social and cultural values. This is where empirical research informed by the human and social sciences becomes relevant.

Within the values-based practice framework, its function is seen primarily in sensitising health professionals about values that may need exploration and less in providing them with specific knowledge about specific values. To go back to the dementia screening example, in a study on a retirement community residents' perspectives on routine screening for memory problems, the views were polarised — 51% of the participants were unwilling and 49% were willing to accept such screening.¹⁵ Knowledge about the patients' perspective in general cannot serve as a substitute for identifying a particular patient's perspective, even when the level of agreement among patients is higher than this example suggests.

This general-particular difference in learning about values may sound self-evident, yet the need for a differential approach does not seem to have been accommodated, for instance, in medical education. In recent years, significant steps have been taken to develop the future health professionals' skills to understand and appraise social and human sciences research. The skills to deal with the values in each individual patient-health professional encounter are, however, different.

Values-based practice and the patient-centred approaches

In keeping with the precept of patient-centred care, it is the values of the patient that currently dominate theoretical frameworks, research studies and policy documents. From a values-based practice perspective, it is critical to supplement the focus on the patient's values with increased attention to a wider range of values. This includes the values of providers; of informal carers and the family; of society; and the values embedded in research, the organisation of services and policy documents.

Awareness of such values is important, as they may hamper the recognition of the patient's values. Values cannot be accessed as selectively as we may wish, in spite of what seems to be suggested by appeals to health professionals' for holding their values back.¹⁶ Health professionals' recognition of their own values — personal and ensuing from professional background and occupational roles, is a necessary step in reaching out for the patient's values. If, for example, a GP is unaware of his prejudice against

obese patients, or a psychiatrist cannot distance herself from the ideas about beneficial treatment endorsed by her profession, it is unlikely that they will appreciate the reasons behind their patients' preferences and concerns or will altogether fail to elicit these.

Values other than the patient's are and should be legitimate parameters in the decision-making process. Within the values-based practice framework, values are seen as dynamic and decisions as negotiated within the context of the values of a number of relevant stakeholders. A narrow attention to the patient's values may be questionable in terms of feasibility and ethical merit (for instance, health professionals also need to have their values respected), but, more importantly, it may prevent an optimal decision from being reached. This may happen even if the patient's perspective is the only one being considered, as when a patient's family 'sabotage' his and his physician's joint decision for diet-only control of diabetes. Acting on the patients' values as on something fixed and final, without suggesting other possible points of view, may also deprive patients of welcome possibilities to reconsider their choices. Thus, the values-based practice framework is not exclusively oriented towards the patients' values. Yet it suggests that to elicit and explicitly incorporate the values of other relevant stakeholders in the decision-making process is far more effective in respecting the patient's values than granting these an exclusive priority.

How does values-based practice relate to evidence-based medicine?

Values-based practice is not at odds with evidence-based medicine. The latter recognises that research evidence is only one consideration in clinical decision making,^{17,18} and has sought ways of responding to two major types of criticisms — that of a limited usefulness for individual patients and that of a narrow definition of evidence.¹⁹ Sackett *et al*, for instance, define evidence-based medicine as the integration of best research evidence, clinical expertise and patient values.⁵ Other authors find other forms to include parameters similar to expertise or values by targeting what they perceive to be a narrow definition of evidence. Upshur, for example, suggests a four-pronged taxonomy of evidence: quantitative-general, quantitative-personal, qualitative-general, and qualitative-personal types of evidence.²⁰ Within this conceptualisation, evidence-based medicine might be seen as focusing on ways for obtaining reliable quantitative-general evidence, while values-based practice might be seen as concerned primarily with ways for eliciting authentic qualitative-personal evidence.

There are, however, situations in which strong evidence is available, but the patient's values seem to be in conflict with it. For example, while the benefits of smoking cessation and reducing raised blood pressure, lipids, overweight and HbA1c levels are all well recognised for people with diabetes, some patients are unwilling to compromise their quality of life by taking action in these directions. In values-based practice terms however, this is not a conflict between evidence and the patient's values, but of one set of values (such as favouring a reduced risk of complications) and another set of values (such as favouring day-to-day quality of life). Consequently, the way to deal with situations in which evidence seems to be in conflict with values is by eliciting the conflicting values and exploring possibilities for bringing these closer together.

How can a practice become more individual values-based?

What changes are needed so that clinical practice can become more individual values-based? In the rest of this paper we will outline some educational and research priorities, as seen from the perspective of the values-based practice framework.

Education and professional development

Education and professional development are seen as the primary focus of change that will facilitate practising in a more values-based way. The philosophy and concerns of primary care are such that the importance of values is unlikely to be contested by health professionals working in this area. The emphasis of change will thus lie in raising awareness of the diversity and manifestations of values and the acquisition of skills to elicit and negotiate values. Enhancing awareness of one's own values and the development of analytical and communication skills to elicit the values of individual patients and other stakeholders are primary ways of achieving this.

As a 'good' process of negotiation of values is seen as the means to reaching balanced decisions, the development of skills in negotiating values is considered the second crucial component that will support practising in a values-based way.

Box 2. Approach to searching the academic literature on values in primary care.

- ▶ Searches were run in Medline, PsycINFO, CINAHL, International Bibliography of the Social Sciences, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Copac, Social Services Abstracts, Caredata Abstracts, and Philosophers' Index, by using free-text words (such as 'perspective', 'perception', 'attitude', 'belief', 'experience', 'qualitative'), thesaurus terms (such as Medical Subject Headings) and, for shorter time periods, by screening all citations retrieved by the relevant condition-word (for example, obesity). The year limits were different, most often between 1 and 10 years

Box 3. Operational definition of 'values'.

- ▶ Personal existential values
Values related to one's views about what is important in life and the kind of person one has to be
- ▶ Social/ cultural/ ethnic/ group values
Values securing the structure and functioning of different societies, cultures and smaller groups within them; a major influence on the value systems of individuals belonging to them
- ▶ Disciplinary/ scientific/ theoretical values
Basic, necessarily value-laden, assumptions of the different disciplines, theories, models and professions
- ▶ Processes of assigning values
Processes of deciding whether something is good, worthwhile and important
- ▶ Processes of selection, of singling out
Processes of defining what the important and unimportant aspects of a situation, goal and outcome are
- ▶ Processes of ranking and prioritisation
Processes of assigning value relative to the value of other important things, goals and benefits

RESEARCH DIRECTIONS

A values-based practice should be grounded in an adequate knowledge base. To assess the current status of the latter, we performed extensive literature searches on conditions that are often seen in primary care. Most of the searches focused on obesity and overweight, with supplementary searches also conducted on diabetes, dementia in the elderly and mental health problems. Primary care is instrumental in delivering care for individuals with these conditions.²¹ More than 13 000 citations (titles, titles and abstracts, and/or full texts) from 10 databases covering publications from health care, psychology, the social sciences and philosophy were considered (Box 2).

The literature searches also served to elaborate our conceptual understanding of values. Drawing on

ideas from philosophical values theory, we were able to distinguish between six groups of values that are relevant to clinical practice (Box 3). Issues from the first two of these groups (personal and social, cultural and group values) have been extensively researched. Research on issues from the other groups (values of the different disciplines and professions and processes of evaluation, selection and assigning priority) is quite limited, which might not be a fair reflection of its potential benefit to practice. A summary of the current state of research on topics related to values, based on the literature searches we performed, is provided in Box 4.

Research on values relevant to health care may appear a weaker strand than it actually is, as it is dispersed between disciplines — health care research, sociology, psychology, anthropology and philosophy. It is scattered in various journals and databases, inconsistently indexed. It employs a vast array of theoretical frameworks, explanatory schemes and vocabularies which are not easily translatable between themselves. In addition, such research often reflects too strongly the priorities of the discipline in which it originates and is not well suited to support decision making in health care.

The availability of research on values varies highly between conditions; certain themes are neglected in comparison to others — for instance, values related to diagnosis as compared to values related to treatment options, or culture- and ethnicity-related values as compared to the nature and dynamics of evaluative processes. The same applies to certain stakeholders' perspectives, especially if they are considered inferior to the health professionals' ones — for instance, the patient's perspective in research on overweight and obesity is notoriously underrepresented.

Studies are rarely encountered that bring home the disagreements about values by directly comparing the views, perspectives, starting points of different stakeholders, either in the same study or using the same design in parallel studies (as in studies juxtaposing lay and professional models of disease or the models of different health professionals). More research needs to be done that makes unnoticed values evident, highlights differences of values where the latter have been considered shared, explores the nature of evaluative processes and relates all these to decision making and outcomes. Such research may well require the development of novel methodologies.

CONCLUSIONS AND LIMITATIONS

It is not an easy task to justify the need for a new approach to values in health care. Appeals for greater attention to values may elicit reactions ranging from 'this is already being done' to 'this may open a door

Box 4. Summary conclusions from literature searches on values in primary care.

- ▶ Values have been researched extensively in a number of disciplines and from a variety of theoretical standpoints, but the studies and discussions are scattered across databases and journals and poorly indexed and abstracted
- ▶ The range of values impinging on health decisions is wide and many of these are not intuitively recognised as related to health
- ▶ Differences between health professionals' and patients' values and perspectives seem to be under-researched or often discussed in terms of patients' inadequate knowledge
- ▶ Differences between health professionals themselves are under-researched and seem to be underestimated
- ▶ Approaches to identifying and bringing together research studies related to values and to considering their findings relative to one another will enable a more effective application in health care practice of social and human sciences-informed knowledge

to a “Pandora’s box of idiosyncratic, bigoted, discriminatory medicine”.¹⁶ In this paper we have argued that, firstly, values affect each and every health-related decision and by keeping the door to the values box closed, we may do harm rather than good, and secondly, approaches to values that we currently have at our disposal tend to miss some important manifestations of values and lack the adequate skills-development component to help deal with values in everyday clinical practice.

In this paper, we have outlined some basic ideas of the values-based practice approach — an approach which maintains that values are more numerous and complex, and less shared and transparent than normally thought; which gives values significant weight in clinical decision making; which suggests processual rather than rules- or outcomes-based procedures in negotiating values; and which emphasises skills in dealing with individual values rather than the accumulation of generalised knowledge and detailed guidelines.

Values-based practice is likely to deliver more with specialities and conditions in which the relevant values are less shared. In primary care, similarly to mental health, a diversity of values is the rule rather than the exception, and a values-based approach, grounded in its respective knowledge base, is likely to be of particular use.

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