1 The Emergence of Evidence-Based Practice

Mike Thomas, Mike Burt and Joy Parkes

Evidence-based practice (EBP) is currently the dominant model of health care intervention in the United Kingdom. As it values measurement and quantification, it has gained this status in a relatively short space of time, helped by a number of political, managerial and philosophical drivers emerging in separate arenas. EBP is not, however, new and has been the driving force within the quantitative science paradigm throughout its historical development and could be viewed as the bulwark in its battle with the developments of social conflict theory and the popularity of qualitative research methodologies within the social sciences.

The adoption by the medical profession of EBP and its subsequent support by the Cochrane Collaboration (a not-for-profit organisation supporting the practice and dissemination of systematic reviews in healthcare) may be seen as its entry into the modern context of healthcare, and its use is now widespread in all practice-based health professions. Its central tenets are that all healthcare interventions should be based on best evidence, which may be local, and based upon action research, and that it should be effective, particularly in comparison to other interventions. Effectiveness (achievement of desired outcome), alongside efficiency (productive with the minimum of waste or effort), meets one of two governmental requirements for public spending on care, and central support for EPB can be seen in the introduction of the National Institute for Clinical Excellence (NICE), now known as the National Institute for Health and Clinical Excellence.

The medical profession prides itself on its objective, scientific past, although this may not always be observed in clinical practice. Philosophy may be said

to have as much of a claim to the truth as any science. A reflection upon one's own values, followed by exploration, discovery and confirmation may be seen as equally important; a final knowledge of those values adding to the efficiency of the practitioner. The training of potential medical staff involves the study of physical sciences. It was not too arduous for the profession to apply the concept of effectiveness to quantitative approaches such as data collection, particularly when the Cochrane Collaboration produced systematic reviews on available published data alongside guidelines produced by NICE regarding the introduction of new interventions.

It is interesting to note that, in the UK publicly funded health system, effectiveness is allied to cost. Thomas (2008) observed that effective, widely applicable interventions reduce service-user symptoms and poor health, resulting in an important behavioural change – namely, the service user requires less public-funded intervention. Thus, intervention that is cost-effective is also viewed as efficient. There is a value placed on effectiveness and efficiency that places a moral obligation on modern healthcare practitioners, and reflective conversation is at the heart of a commitment to improve practice. It is proposed that, in essence, the health and social care practitioner has a moral responsibility to provide effective and efficient interventions. This is supported by Holm (2004), who also notes that EBP attempts to control health and social care costs, imposing a moral obligation on practitioners to provide evidence that any intervention used is effective.

Evidence-based practice provides a rationale for politicians and policy makers to gain some control over spending. The argument that EBP also allows practitioners to abandon ineffective interventions and introduce better models allowing politicians to manage a finite financial budget may appear hollow during a so-called credit crunch when billions of pounds may be found to bail out large financial institutions. EBP, in effect, has to formalise both the preferred quantitative approach of the last 20 years alongside a wider acceptance of qualitative approaches, providing a clearer impression of what service users need, together with what they increasingly want.

EBP does allow different health and social care practitioners to explore and study interventions from their own practice standpoint. Medicine, according to Sacket et al. (2000), employs evidence-based approaches because it allows the practitioner to use diagnostic treatment and rehabilitative regimes that have themselves been rigorously examined. Medical practitioners can have the confidence in their own clinical skills to balance the risks and benefits of different interventions, reaching a judgement on which course of action to take whilst taking into account the service user's concerns and expectations.

A doctor may find a fair proportion of any accessed data to be quantitative and the same model espoused by Sackett et al. (2000) could be used by a

health professional or by a social care professional accessing data that is more qualitative by design and content. This is understandable given the biological determinism found in the curriculum of medical and health sciences education, compared with the social construct focus dominant in the curriculums of other professions such as social work. Yet the central core of EBP is its emphasis on good, solid research which demonstrates the effectiveness and efficiency of interventions and, importantly, attempts to retain the service user and carer views of intervention itself, the so-called acceptability principle. This individual perspective can, in turn, provide some defence against a generalised approach to evidence-based studies.

The use of EBP has spread since the early 1990s and is now firmly established, an achievement worthy of mention. It is not often that a movement gains such widespread acceptance in such a short time frame across so many health and social care professions, policy makers, sections of academia and the government as budget holder. The welfare state as a publicly funded structure has existed for more than 60 years, but proponents of EBP, whilst claiming a response to the culture of hearsay practice, have made no claims that, prior to its adoption, the nation's healthcare was based on invalid or unreliable data as illustrated in Vignette 1.1. They have however come close with the insistence that EBP does lead to a cessation of inappropriate invalid practices.

Vignette 1.1

My doctor always used to tell me to go to bed and lie flat when I had lumbago. Now, he calls it back pain and he has sent me on a course where they tell me to take pain killers and keep as mobile as possible. How come it can suddenly change like this? I used to enjoy my week in bed with my wife fussing over me – it brought us closer.

The Political Context of EBP

To understand its adoption, EBP must be contextualised within a historical perspective involving political, philosophical and managerial developments. In medicine, the resurgence of biological determinism coincided with the political and managerial focus of controlling public funding alongside the rise of entrepreneurship as the new business theory. For other health and social care professions, the rise of consumer power, of advocacy and internet groups and of the independent sector has impacted on service-users, claims for more autonomy and control over their own care.

With the change of focus, the NHS altered beyond recognition from its roots in social welfare. Long-term care moved to the fee-charging private companies now termed independent care providers from the District General Hospitals. The Ambulance Service and the primary care providers converted to semi-independent NHS Trusts, the 1990 NHS and Community Care Act requiring Trusts to behave like businesses and be active in the marketplace. This social engineering became clear a year later when, in 1991, the NHS was again restructured to encourage the invention of a new internal market. Regional Health Authorities were re-designated Commissioners and instructed to purchase healthcare from the provider Trusts now selling their services. Both parties formalised these arrangements through contracts, although such contracts having no real basis in contract law, thus demonstrating the centrally controlled power held by government. The Department of Health, however, ensured commitments made in these contracts must be honoured.

Effectiveness and efficiency, originally measured through the provision of local services to meet local targets, now faced a fundamentally different measurement. Provision of service had still to be focused on local needs, but annual budgets were abandoned. Trusts were instructed to both generate their own income and to compete against other local services, particularly through the strategy of undercutting each other, an added benefit being the reduction of centrally allocated funds. This was at a time when EBP was beginning to gain a voice, and the political imperative for the new market was increasing efficiency and user choice.

Talbot-Smith and Pollock (2006) highlight the fact that the previously held local pride in building a hospital was now dead. Between 1990 and 1994, 254 hospitals were closed in England and Wales. During these years, the government introduced a new tier of resource-intensive service into the health sector. Trusts desperate to avoid closure spent more and more funding on contract management, competing for the tender of risk management and financial services. To add to their problems, the government used the 1990 Act to allow private profit-based companies to hold contracts to deliver estates, capital management and technological provision. These were to be paid not from what had previously been a Department of Health service (regional offices being closed), but from the Trust budgets. As Talbot-Smith and Pollock (2006) observe, the Trusts were now trading in the newly invented health market, selling their services to service brokers (Commissioners) and, in turn, buying consultancy services to keep their organisation competitive against other market players including other parts of the NHS.

This competition forced some out of the market and the merging of others. This removed the financial burden on central government. Local services, particularly capital estates, expanded to take on the extra services now being

offered from a smaller number of NHS Trusts. Private, independent, profit-orientated companies were allowed to form a partnership with Trusts to erect new buildings, expand existing estates and operate the services such as maintenance and cleaning in these buildings and, in some cases, share rental leases for retail outlets. Much like a mortgage or long-term loan, the profit-based partner would be paid for their contribution, the Trust paying them over a long period of time, guaranteeing income in excess of 25 years in most cases. As we have seen, over 250 hospitals closed in the three years of the new market and by 2005 only 50 hospitals had increased their building or estate; 42 of these were held in Private Finance Initiative contracts (Talbot-Smith and Pollock 2006).

Since the turn of the century, the primary care sector has been assimilated into the current Primary Care Trusts (PCTs) and the effectiveness and efficiency focused on preventative and community care. Government targets are aimed at reducing cancers, strokes, cardiopulmonary problems, simultaneously transferring much of the care for chronic and long-term conditions into the community. Consequently, Primary Care Trusts have recently been split into two services, one a commissioning arm buying services from providers and the other the provider arm. The old District General Hospitals which evolved into NHS secondary and tertiary Care Trusts have undergone yet another change; several of them are now designated Foundation Trusts with even more independence from central control. Via a tendering process, they can compete for the delivery of services against local PCT providers, independent organisations and the voluntary sector and can purchase other sites in order to expand services.

The system is now embedded in contract law, and there are a number of regulatory bodies which oversee quality and provide guidance on provision, tendering, Foundation status and local requirements. The PCT commissioners in turn base their decisions regarding tendering on efficiency (cost), effectiveness (achievement of outcomes) and acceptability by the local population.

Compared to the closure of the great industrial bases in the UK, such a radical dismantling of a centrally funded National Health Service occurred with little social unrest, with managerial enthusiasm in a majority of cases, and all in the last 20 years. When presented against the privatisation of the health system and the need to operate within highly controlled budgets, the impact of evidence-based practice is, politically, not too surprising. A political lead was taken on adopting such a system as EBP, its attractiveness to the political leaders self-evident. It removes ineffective interventions, introduces new, more effective care allied to efficiency and it has a strong element, linked to action research, of the user's perspective in its philosophy. The science of healthcare delivery via EBP was promulgated at just the right time to meet

government expectations. It also lent credibility to the decision-making of managers, providing a rationale for discussions with contract holders who, in turn, had been through a socio-cultural change.

EBP in Social Work

The tension between evidence and values-based approaches has featured in the development of the social care and social work knowledge base since the mid-Victorian period. The Charity Organisation Society was formed in 1869 to provide an alternative to indiscriminate charitable giving, attaching importance to what they regarded as a scientific approach to distributing charity. Their casework approach thoroughly examined the individual circumstances of applicants, and determined how specific provision might be successfully used by the recipient (Woodroofe, 1961).

The development of knowledge from surveys of the poor, the impact of economic cycles and the social sciences reduced the significance attached to individual culpability, informing the development of a much wider range of provision. Harris (1999: 48), from the perspective of the first part of the 19th Century, argues that 'one of the most striking features of 'social reform' literature over the next 30 years was to be the continuing interaction between sociological theory, social philosophy, empirical investigation, casework, and the analysis of practical social policy'. She highlights in the development of this social-scientific culture, the role of the Fabian Society, local Charity Organisation Societies, and, subsequently, the British Institute of Social Service, the Guild of Help movement, and the councils of social welfare and civic trusts of the Edwardian period. Harris (1999) argues that the development of social welfare provision was influenced by the social philosophy of the Idealists, and notes, in particular, the role of Edward Urwick, the first head of the Charity Organisation Society's School of Sociology in 1903 and, subsequently, the first Head of the Department of Social Science and Administration at the London School of Economics in 1912. Harris suggests that, after the Victorian and Edwardian periods, social scientists became increasingly aware of the limitations of biological and natural-scientific models. Idealist academics and philosophers were involved in establishing early departments of social science where the first academically trained social workers and social scientists were taught. He further suggests that 'In spite of its emphasis on speculative theory systematic Idealism did not discourage empirical social research, but claimed that the facts were meaningless without an explanatory framework derived from subjective experience and *a priori* reasoning' (Harris, 1999: 51). This

framework promoted the creation of a state based on the contribution of individuals, including the poor, as responsible citizens to society.

The application of social science knowledge to individual cases within social case work of the period was formulated by Richmond's (1917) influential *Social Diagnosis*, written explicitly in the USA to assert that social work could be regarded as a profession. She wrote on the systematic collection of social evidence, drawing inferences, developing hypotheses and making interpretations. Clement Brown (1939) identifies this tradition in social case work in the UK, also drawing attention to the different role of a social worker who emphasises the importance of a continuing relationship with a service user through which change is effected, itself a role developed in the USA and influenced by psychoanalytic theory.

Following post-war legislation, social work roles developed within state provision. The journals of the different occupational groups contained articles which were based on empirical research and used to promote a particular development for policy and practice. However, the range of material was sufficiently limited to the extent that very little academic research had been carried out in the UK. The National Institute for Social Work Training, established in 1961, included a centre for research. The Seebohm Report (1968) advocated that social service departments should be established, recommending that more research should be carried out within these. The influence of the study of sociology in the 1960s enhanced social workers' understanding of the family, but also led to a radical critique of the casework method which was perceived to locate problems within individuals. This radical critique argued that the problems which disadvantaged people experienced arose from the structural inequalities of society, and that they should be addressed at that level. Social service departments established a research function when they were created in 1971 and the Department of Health set up the Personal Social Services Council, an independent advisory, research and development body.

The effectiveness of social work became an important issue in the 1970s. Goldberg and Fruin (1976) pointed out that some social workers took the view that research and social work practice were not compatible because of the uniqueness of individuals and that such a therapeutic relationship could not be scientifically analysed. They suggested that social workers sometimes resisted the clarification of goals in their work. In her summary of social work research, Crousaz (1981) points out that evaluative research was very limited in social work, the size and design of studies failing to meet the requirements of rigorous experimental methods. She argued: 'If evaluation is to go further than a limited measure of success or failure according to the criteria set up, there must be some attempt to isolate the factors which might contribute to

success or failure … It may in fact be just those aspects of the relationship which are most unconscious and hardest to articulate and categorise: empathy, caring, or a social worker's own personality and adjustment which are the key features. Or it may be aspects of the client not generally measured, such as motivation to change' (Crousaz, 1981: 37).

The 1980s saw the continued advancement of evidence-based and values-based approaches as alternative knowledge bases for the development of effective practice. Sheldon (1986: 240) argued for 'the fostering of a greater respect for empiricism; for putting behind us our tendency to practice or to teach on the basis of ideas that we happen to find congenial, rather than those which have stood up to practical test'. He draws attention to the predominance of the casework method in studies, mainly from the USA, up to 1972 which failed to show the effectiveness of social work practice. He contrasts these with studies from 1973 onwards, again primarily from the USA, which were more specific in focus, used smaller samples and in which social workers made more direct interventions in behavioural problems. Sheldon quotes Fischer (1985) who suggested that by 1973 there had been a failure to demonstrate that systematic improvements could be made, beyond the natural power of the environment or the passage of time, to a wide range of problems encountered by service users, but that we certainly knew about values!

Along with other professions, the use of the specific term 'evidence-based practice' started to be used within social work during the 1990s. Webb (2001) suggests that the article by Macdonald and Sheldon (1992), 'Contemporary studies of the effectiveness of social work', prepared the way the way for evidence-based practice in the 1990s. Webb offers a detailed critique of the attempt to apply an evidence-based practice approach to all decisions, questioning whether scientific approaches to behaviour were themselves able to provide the evidence that they could be made to work. He expresses concern that although the use of research evidence in practice in itself is not problematic, the assumptions of evidence-based practice as a methodology for practice itself are too limiting in enabling practitioners to respond to the range of situations they face in practice. He further states that it feeds the managerial agenda and because the basis of the approach is in behaviourism and positivism, it is flawed. It assumes that a rational agent is in a position throughout their work to apply obvious conclusions from findings to logical decision making. Webb (2001: 74) suggests that 'Evidence-based practice effectiveness sits comfortably alongside the new managerialism in social work. The recent imposition of a cognitive-behavioural model in the probation service in England is a further example of this tendency to enforce standardised methods and supposedly scientific models of intervention'.

Sheldon's (2001) reply to Webb emphasises that alternative methodological approaches have not been shown to be effective in social work and are advanced because academics may favour them. He suggests that there is a great deal of evidence that behavioural approaches do work. In their review of this debate, Butler and Pugh (2004) assert that there are basic problems surrounding the assumptions made by supporters of evidence-based practice regarding the objectivity, not to mention the reliability, of observation itself, of assessing different sorts of evidence, and of the processes of inference which lead from evidence to explanation. They reject a hierarchy of methodologies which places a positivist approach at the top and subjective approaches such as narrative accounts of personal experience at the bottom. They further argue that isolating actions to be examined from their broader contexts leaves the fundamental causes of social problems unexplored, thereby attempting to depoliticise social work research and social work itself.

Gray and McDonald (2006) have questioned whether the nature of social work practice can be reduced to measurable and quantifiable data. They postulate that 'the adoption of evidence-based practice can be best understood as a continuation of long-standing attempts to deal with the ubiquity of ambiguity and uncertainty in social work' (Gray and McDonald, 2006: 12). Van de Luitgaarden (2009) argues that evidence-based practice is related to a rational choice model of decision making. He points out that scholars in the field of judgement and decision making have found this approach impractical for certain types of decision making and that it is mainly those types of tasks with which social workers are principally concerned. He points to the significance of perceptions rather than measurable factors, and of constantly changing factors in social situations.

The modernisation of social care since the advent of the Labour governments from 1997 has led to an increase in various forms of support for the development of research based on the government's principal concern to identify and disseminate evidence of what works. Foremost amongst the initiatives has been the establishment of the Social Care Institute for Excellence (SCIE) in 2001. SCIE is responsible for disseminating research knowledge to the occupational sector of social care. The Joint University Council Social Work Education Committee (JUCS-WEC) has published a strategy to significantly improve the quality and quantity of social work research in higher education institutions in the UK (JUC-SWEC, 2006). The report states that a long-term strategy is required to build a research capability within social work, which has developed as an applied policy and practice discipline but with significantly less funding than is obtained by, for example, health research. The report refers to the evidence base of social work but prefers the term 'evidence-informed practice'. Within social work departments of Higher Education Institutions, research networks have become active, including Making Research Count

and Research in Practice. Commensurate with policy developments which involve service users and carers in active participation in meeting their own care needs, there is an increasing involvement of service users and carers in directly carrying out research as shown in Vignette 1.2.

Vignette 1.2

My husband is in the early stages of Alzheimer's disease. Recently we were both invited to participate in a research study looking at what support needs to be in place for both me and my husband. We are both in different focus groups which explore our views from our own perspectives. My husband was a principal lecturer at a local college and he feels this will be his final opportunity to have his name on a publication and also, because he is quite well known, it will make people want to read it. For me it will be the first time my name has ever been in print and that makes me feel that what I have to say is important.

At the beginning of the new century, the current position is that there is a strongly identified need for a significant increase in the availability of research evidence to inform policy and practice in social work. However, this drive is within the context of valuing the validity of different epistemological bases. It is accepted that where there is evidence available of effective interventions, these should be used to inform the practice social workers are frequently involved in, in complex social situations. Consequently, social workers can be expected to be reflexive about the intentions, nature and impact of the way in which they engage with service users and carers and the dominance of EBP in healthcare has not yet made a major impact in social work. It remains to be seen whether social work will be able to resist the governmental culture which emphasises efficiency and effectiveness in financial rather than human costs.

The Management Culture

The culture of efficiency has been closely aligned to quality and the belief that quality provides a competitive edge in the marketplace providing a guide to value. In turn, value is a disjunctive concept in the sense that the word value has different meanings in different situations. Value is often used to refer to an amount, usually of money, but sometimes of goods that a person can exchange for something else. It may also refer to personal satisfaction in that the amount a person exchanges is within a given range – the 'value-for-money' feeling. It can

also mean the present worth of something to gain something else. That is, the price of an object in a collector's market would have a higher value to a collector than an interested onlooker. Values may also mean moral principles. Balogun and Hailey (2004) suggest that corporate values were viewed by managers in the 1980s as a mechanism to steer organisations towards better efficiency and they were supported in this by the growth in human resource management methods which held cultural change programmes in high regard. There was a strongly held belief in the entrepreneurial spirit which was pushed by the government as not only good business technique, but also morally acceptable.

If organisations provided employees with a package of corporate values which emphasised entrepreneurialism, then the workforce would be more likely to innovate; there would be a decreased need for bureaucratic procedures and, in turn, a reduced interference by management. A twin belief was that organisations would be less risk-averse and more enthusiastic in taking control of their own direction. Later evidence demonstrated that such beliefs were misplaced. For example, the value statements marketed by companies, often in the form of Charters, lost their currency when it became apparent that senior managers were not altering their own behaviours, and the more alert workers disseminated a sense of cynicism when they perceived that management were manipulating the staff. There was also an inbuilt mechanism for undermining the value-based approach when staff did embrace the belief in self-determination; as the company became more diverse in its activities, so the idea of core values became more diluted. This was especially predominant in organisations such as hospitals and services such as community care. The core problems arose from the lack of commitment by senior managers to improve inter-organisational communications and the flow of information. There was also a lack of awareness of the extra work required to involve both staff and service users in the organisational values by the use of workshops, briefings, updates and so on. In the mid-1980s, there was a form of marketing and branding in the commercial world which emphasised values when, in fact, they continued to practise in a profit-orientated way which rejected value-based care.

Lencioni (2002) observed that the public and employees soon saw through these managerial approaches and by the start of this century corporate values were viewed as a capitalist attempt to be politically correct. By then, a considerable amount of damage had been done to those very workers who should have benefited from value-based objectives. The issue appeared to be one of trust between those who managed and those who were managed – ironically itself a value concept. George (2001) suggests that trust is an important organisational virtue because mutual trust between staff increases efficiency, whereas a lack of trust decreases creativity and increases control over the work environment

which leads to loss of profitability. It is interesting that the concept of trust has such a hold in the for-profit business community as trust itself can have different uses in different contexts. At its basic level, trust involves giving to another that which one holds valuable (money, knowledge freedom, information, consent or secrets) and feeling emotionally secure that what is given is safe with the other. Yet Joni (2004) suggests that there is also a professional trust and a structural trust. In the professional context, trust is based on the individuals' knowledge or ability in their field of expertise and their capability to provide informed, disinterested, objective and truthful advice whilst structural trust is based on the roles and responsibilities given to an individual, for example a doctor, nurse, police officer or faith minister, by others either in their contract of employment, by the law or by cultural norms.

A further blow to the customer-first philosophy had been the government's attempts to restore trust in business practices by its insistence on accountability, transparency and public involvement. O'Neill (2002) suggested that the drive for accountability merely led to an increase in bureaucracy, burdening public institutions with increased costs.

Public service organisations have been encouraged by politicians to structure themselves in a market-orientated way so that the capitalist drive for efficiency and effectiveness has an impact on public spending itself. The new emphasis on customer satisfaction at this time was fortuitous. It meant a closer relationship, superficially at least, between public-funded bodies and the ethos of the market; both accepted the ideology of social and moral responsibilities, both claimed to meet customer needs and provide good services and both accepted the inclusion of interest groups in their strategic planning.

The dynamism of the free market was viewed as an important catalyst to change in the moribund health and social care system in the UK. The simultaneous growth of evidence-based practice in the public services reflected the emphasis on efficiency and effectiveness which motivated the drive to increase profits in the business sector. In many ways, the evidence-based care model is a capitalist device with the added value of being ethically acceptable. It was, therefore, very timely and welcomed in different areas: by the medical profession because of its science-based results; by managers because it provided socially acceptable rationales for health and social care strategies; by auditors because it provided comparative measurements and league tables; by commercial companies because it provided a selling angle and by politicians because it provided possible reductions in public spending. Overall, evidence-based practice can be seen as good value for money. There has, however, been little, if any, detailed consideration of the nature of these values themselves and whether the concept of value is commensurate with business practices and evidence-based care.

Values-based Care

The concept of values-based care has been gaining ground within health and social care services over the last decade. This holistic form of care has already been implemented within some areas of mental health services and community services (Olsen, 2000) due, it can be reasoned, to unease with over-reliance on evidence-based practice. Values-based care is a blending of the values of both the service user and the health and social care professional, thus creating a true, as opposed to a tokenistic, partnership. It is suggested that the importance of values in care may have been overlooked because they are presumed to be shared unless clearly openly conflicting (Olsen, 2000). The Royal College of General Practitioners (RCGP, 2007: statement 1) recommends in their core RCGP curriculum, that all general practitioners should be able to 'understand the nature of values and how these impact on healthcare' and 'recognise their personal values and how these effect their decision-making'. Thus, the importance of values-based care for this group of professionals is clearly stated.

NHS Education for Scotland (2008), which as a country may be considered to be driving the UK move towards values-based care (see, for example, Mental Health (Care and Treatment) (Scotland) Act 2003), published a list of values according to three staff groups, a selection of which are listed here:

Delegates at a conference regarding mental health recovery

- Core beliefs
- Principles – cultural, individual
- Anything that's valued
- Social values
- Valuing neighbours
- Your perspective on the world.

Managers/Chief executives

- Right and wrong
- Belief systems
- Ideals and priorities
- Things that govern behaviour and decisions
- Conscience.

Trainee psychiatrists

- What you believe in
- Principles
- Personal motivating force
- Primary reference points.

As can be seen, these are broad headings which encompass multiple ideas and personal philosophies. Values-based care cannot be fitted into neat pigeon holes, nor can professionals be given a simple 'how to' manual. This model of care leans heavily on the professionalism of the health and social care worker gained through knowledge, experience and respect for service users' views. Little (2002: 319) when discussing healthcare stated that 'If we are to seek a new model for a reconstructed view of healthcare, the term "values-based medicine" might have more power and relevance than "humanistic medicine"'. Health care provision cannot be separated from universal values such as caring and compassion and thus consideration of individual values cannot be ignored, especially when these are in opposition to evidence-based practice (Olsen, 2000), as illustrated in some of the vignettes contained within this book.

The Nature of Values

As previously noted, the concept of value can mean different things to different people, depending on the context in which it is applied. In general, however, a value is likely to be based on the desirability of acquisition in terms of its immediate or potential practical benefits, for example toothpaste as immediate and stocks or shares as potential benefits. The price of such objects is determined in monetary terms – a different type of value in that the cost of something will depend on its accessibility and whether the buyer feels the cost is a fair exchange and value for money. This model has been increasingly applied to health and social care because value in economic terms can be measured in both mathematical quantities (the amount of money, materials and resources) and customer satisfaction, whilst personal health and social circumstances (well-being) can be viewed as a valuable asset. This model easily absorbs scientific approaches of evidence-based practice. Evidence-based care can provide an additional evaluation to its therapeutic value by embracing the economic concept of value, thereby making comparisons based on efficiency and effectiveness. Such perceptions of value, whilst deeply ingrained in society, are based on whether something is perceived as desirable or not. However, despite repeated attempts by economists to forge a link between for-profit capitalist value and ethics, the concept of values as moral principles remains elusive in the economic market. As moral principles, values provide guidelines for individual and societal actions and, additionally, can be ascribed to the regard one person has for another – their integrity, trustworthiness and moral character. These two definitions of value can often be

opposed when related to those characterisations and actions which individuals undertake in the pursuit of profit. Here, the stress is less on what is valuable and more on subjectivity in the context of personal judgements based on moral acceptability. A classic example is the debate which surrounded HIV vaccinations, and whether pharmaceutical companies should provide lower-cost products to economically poor countries. The companies initially took the view that their investments required a profit return. Only after they accepted that such a stance reflected poorly on their organisational values did they start to provide cheaper products, and only after action groups had lobbied for values as moral principles rather than monetary gain.

Robinson (2001) discusses value judgements in terms of a prioritisation model in which an individual gauges the importance of personal values through a form of cognitive filtering, citing Raths et al. (1978) who proposed that an individual examines choice, worth and behaviour in order to prioritise values. Choice involves freedom to choose, an environment providing comparative choices and a consideration of the consequences of the choice made. Worth involves examining the desirability and contentment provided by whatever one chooses to value and articulating and affirming that choice in the public domain. Behaviours include the application of a chosen personal value to one's life and applying it repeatedly. One of the important consequences to consider is the impact of a chosen value on others close to oneself and on society generally. The conflict of holding a personal moral value which conflicts with a generally held societal value can lead to moral dissonance. Examples may include a politician who, believing in peace through dialogue, may have to present a public face of supporting military intervention in order to protect their own career, or a minister of faith having to defend scriptural teaching during social unrest, or the situation described in Vignette 1.3.

Vignette 1.3

As a Health Visitor I remember calling on one family who were struggling with child-rearing. We had discussed smacking in the past and the mother felt that as it had never done her any harm she felt it was a good way of teaching her child right from wrong. Despite all my explanations, and my strong belief that smacking is wrong, during this visit I had to watch silently as she smacked her three-year-old child when he pestered her for attention because smacking is not illegal and society generally supports it.

John Locke (1974) examined the confusion surrounding concepts when a complex idea such as a value is reduced to too many simple ideas, famously giving the example of not assuming that just because an animal has spots it must be a leopard. He argued that words and their definitions not only lead to a taxonomical order, but also help the individual avoid confusion. Words aid a person by making clear the distinction between things, and the similarities and differences between things that appear on the surface to be the same. Some ideas, however, are simple and others more complex. Locke (1632–1704) suggested that simple concrete concepts are archetypes, and a visual presentation will often succeed in getting everyone generally to accept the idea – a chair, for instance, can be seen as an archetypical concept. More complex concepts require the relationships between ideas to be made clear. For instance, a car is an archetypical concept in the modern world but, as there are different types of cars and different models, the archetype becomes more complex. Another layer would be transport where the idea of car would also have a relationship with train, bus and plane. But if an idea is used outside its context, or replicates existing words with different meanings, it loses substance. It becomes an inadequate method of conveying ideas because it causes confusion. The use of the word value in both moral and commercial contexts, and the inter-weaving of meanings in different settings, may have provided an intellectual device to merge public funded health and social care with for-profit organisations. Reinforcing this view, Smith (1929) states that Kant (1724–1804) takes a slightly different approach to Locke, suggesting instead that judgements can be made based on both ideas and ideals. Both have the power to provide a practical basis for actions and, therefore, act as regulatory principles for a person's behaviour. Moral concepts, however, do not necessarily rest on reasoning alone, but also on the pleasure (or displeasure) of the consequences of actions. Kant argued that some ideas appear complex, but are actually archetypes, suggesting, for example, that virtue and wisdom can be seen as moral values but can equally be viewed as regulatory principles. This is because, when related to rules of law or cultural behaviours, they provide boundaries, preventing completely free actions. Kant would accept that no individual fully achieves a wise and virtuous life. This ideal acts as an archetype because it can be used as a comparative social model, placing values on socially accepted ideas and behaviours. Even though such concepts have no objective reality, they nevertheless constitute an idea in the mind which allows the individual to evaluate moral worth and make a value judgement. The attainment of an ideal is, for Kant, unrealistic and so we allocate value to the value concepts themselves and these values act as archetypes for personal behaviour and actions.

Mautner (1997) defines another perception of values. He writes in his dictionary that some actions can be value-free, especially in empirical science, because research alone does not establish whether some thing, or some action or some state is good or bad. These are value-neutral until some-one provides a value-judgement to the results. Scientific inquiry can provide causes and effects, predictions and explanations, but not value-judgements. This argument has some exponents but research does not occur in a vacuum. Inevitably, it must have value-judgements and applicability placed on its results; the concept of value-free research is not widely accepted.

Robinson (2001) sees some difficulties with Raths et al.'s (1978) model and its roots in Kantian's regulatory principles. He asks who, for instance, defines a value as socially desirable and whether a model based on reason-ing makes assumptions that an individual is both rational and able to make choices. Even then, there are potential clashes seen in the periodic requests from service users and families to be given medication or therapies that are deemed too expensive by regulatory bodies. Even when the majority recog-nise the reasoning behind such efficiency arguments, the value-judgements can alter when faced with the individual or a loved one who is affected. Those with power and authority will want to impose the values of the majority for cost-effective care, but the individual practitioner may want to impose a moral principle of valuing individuals. Illness and poor social circumstances can also affect choice and decision making and the articulation of moral choices can be difficult in emotional environments. Robinson thus questions how an individual can demonstrate moral values if personal values are left outside the working environment.

Robinson et al. (2003) stress that value prioritisation requires a degree of reflective skills and the opportunity to explore values with others to ascertain the consequences of one's choices and any possible future responses to moral actions. In other words, value-judgement is a learned ability and does not occur spontaneously or independently. Edwards (1998) suggests that this learning itself occurs in a relational and complex environment where those that provide moral guidance or judgements are themselves morally judged. In the context of positivist research, the investigator is required to leave their own values and ideals outside the research paradigm itself, an appar-ently contradictory stance unless the research is then subjected to value-judgements by external referees acting as guides to the research method's reliability.

Russell (1961) takes the historical view, discussing Hegel's (1770–1831) stance which supports Robinson et al.'s (2003) view, that the ultimate imposition of moral authority is given by the state. The issue of social

power, therefore, cannot be disengaged from the consequences of value choices. Most democratic governments manage a benign form of authority in such areas by condoning organisations that are not deemed harmful to the common good, allowing interest and pressure groups a certain amount of independence. This political philosophy is an adequate framework to support differing social interests, and its basis in law and rationality allows health care practitioners to hold and practise particular aspirational values of their own. In health and social care settings, the complexity approach (discussed in detail in Chapter 2) provides a rationale for the inclusivity of users, carers and workers, supporting the case for valuing user involvement in service delivery. This is because an individual can represent a group interest, and is therefore a means to reach aspirational ethical values which have a relationship with corporate and political values. By including user representatives in strategic and operational issues, it can be argued that the voice of the community is heard, irrespective of whether individuals bring their own or their constituents' values to the organisation.

EBP can be viewed as an historical movement arising from the medical profession's response to governmental targets regarding health and social well-being. The political stress on efficiency and effectiveness around public spending provides an environment within which a more explicit numerically transparent method of data collection and analysis can flourish. Alongside the political movement ran business and corporate changes in the commercial sector. These focused on organisational values in an attempt to brand products and services as desirable to service users. A synergy between the medical philosophy of learning and practice, political aspirations and commercial exploitation has thus been achieved.

The pendulum, however, may have swung too far towards the 'evidence' for efficiency and effectiveness at the expense of acceptability by health and social care users. EBP has a distinct and robust basis in clinical practice. Its values differ from political and managerial values. Nevertheless, the combination of clinical, evidence-based care, political interference and commercial profits has led to positional aspirations with health and social care services grouped into value-laden league tables.

However, the policy papers that have circulated since the NHS Next Stage Review (DoH, 2008a) indicate that the pendulum may need to swing back towards a user and staff acceptability value system. There is more emphasis on the quality spectrum regarding care, although this remains within the boundaries of effectiveness and efficiency. Nursing and midwifery care, for example, is to be audited on its compassion, safety and effectiveness (DoH, 2008b; Griffiths et al., 2008; Maben and Griffiths, 2008). Evidence will be

accepted using both a quantitative and qualitative methodology with the open admission that the quality of care provided has failed to receive due recognition when compared to competing productivity targets. The new aspects to be measured include treatable conditions, falls, hospital-acquired infections, communication with care providers, medical administrative errors, staffing levels, well-being and satisfaction measurements. The rigour of the data indicators will be overseen by the National Quality Forum which will expect scientifically sound and usable data to demonstrate an impact on service users and national goals. Evidence-based practice is one strong area but equally there will be an expectation that new quality measures will be utilised to demonstrate the impact of care.

The Allied Health Professions (AHP) (DoH, 2008c) have also agreed to develop a set of quality matrices, and will monitor personal health budgets with an emphasis on user control, choice and empowerment. The leaders of the AHP specialties are also asked to understand the realities of working in user-led, but still evidence-based and contestable, systems (McMahon, 2008).

For staff development, the government has continued to stress evidence-based practice (DoH, 2008d: 36) as an 'analytical function for workforce supply and demand modelling and providing a single evidence base for the health and social care systems'. It also signals a move towards value-based care, encouraging and promoting the use of feedback from users and the public in the design of training and education of the workforce. The NHS Next Stage Review (DoH, 2008d) stresses the requirement for health and social care delivery to have a culture which values staff and lifelong services alongside user, carer and public involvement. It must also make use of EBP as a means to provide evidence for the need for clinical services, and as an economic model to measure workforce effectiveness.

Evidence-based practice has also spread to the independent sector. The National Council for Voluntary Organisations (NCVO, 2007) is committed to producing a national research centre. Amongst several key principles will be the involvement of stakeholders in research activities and the development of an evidence-based culture. The research centre will also have an interest in evidence for the values, outcomes and effectiveness of service delivery.

Evidence-based practice is now a reality for the planning and delivery of health and social care in the UK. It is gaining ground in related fields such as education and environmental well-being (United Kingdom Public Health Association, 2007). It provides a robust, reliable and valid methodology underpinning a rationale for adopting values such as effectiveness, efficiency

and acceptability. In certain areas – (pharmacology, for example – it is the most appropriate method of data collection and analysis. In other areas, it is too susceptible to gaming where organisations play their positional aspirations by focusing on specific government performance indicators which, in reality, take resources away from overall organisational improvements.

The current trend is for more qualitative, value-based evidence to be implemented within health and social care environments in an attempt to balance the existing dominance of quantitative, evidence-based evidence and to support the inclusion of stakeholders. In the future, perhaps, reflection may be used to bridge the gap between values and action, confirming best practice whilst discovering new ways forward.

References

Balogun, J. and Hailey, V.H. (2004) *Exploring Strategic Change*. Harlow, Essex: Pearson Education Ltd.

Butler, I. and Pugh, R. (2004) 'The politics of social work research', in R. Lovelock, K. Lyons and J. Powell (eds) *Reflecting on Social Work – Discipline and Profession*. Aldershot: Ashgate, pp. 55–71 .

Clement Brown, S. (1939) 'The methods of social caseworkers', in F.C. Bartlett, M. Ginsberg, E.J. Lindgreen and R.H. Thouless (eds) *The Study of Society: Methods and Problems*. London: Kegan Paul, Tench, Trubner & Co, pp. 379–401.

Crousaz, D. (1981) *Social Work: A Research Review*. London: HMSO.

Department of Health (DoH) (1990) *NHS and Community Care Act*. London: Department of Health.

Department of Health (DoH) (2008a) *NHS Next Stage Review – Leading Local Change*. London: Department of Health.

Department of Health (DoH) (2008b) *Framing the Nursing and Midwifery Contribution – Driving up the Quality of Care*. London: Department of Health.

Department of Health (DoH) (2008c) *Framing the Contribution of Allied Health Professionals – Delivering High Quality Healthcare*. London: Department of Health.

Department of Health (DoH) (2008d) *High Quality Care for All – NHS Next Stage Review Final Report*. London: Department of Health.

Edwards, S.D. (ed.) (1998) *Philosophical Issues in Nursing*. London: MacMillan.

Fischer, J. (1985) Lecture and discussion at Green College, Oxford, reprinted in part in *Behavioural Social Work Review*, Spring.

George, W.W. (2001) 'Keynote Address – Academy of Management Annual Conference 2001', *Academy of Management Executives*, 15(4): 39–47.

Goldberg, E.M. and Fruin, M.J. (1976) 'Towards accountability in social work – a case review system for social workers', *British Journal of Social Work*, 6(1): 3–22.

Gray, M. and McDonald, C. (2006) 'Pursuing good practice? The limits of evidence-based practice', *Journal of Social Work*, 6(1): 7–20.

Griffiths, P., Jones, S., Maben, J. and Murrells, T. (2008) 'State of the art metrics for nursing: a rapid appraisal', *National Nursing Research Unit*. London: Kings College. Available at http://www.KCL.ac.uk/content/1/c6/04/32/19/Metricsfinalreport.pdf [accessed 29 January 2010].

Harris, J. (1999) 'Political thought and the welfare state 1870–1940: an intellectual framework for British Social Policy', in D. Gladstone (ed.) *Before Beveridge: Welfare Before the Welfare State*. London: IEA pp. 43–63.

Holm, S. (2004) 'Evidence-based practice – the role of nursing research', in D. Tadd (ed.) *Ethical and Professional Issues in Nursing – Perspectives from Europe*. Basingstoke: Palgrave Macmillan, pp. 37–55.

Joni, S.A. (2004) 'The geography of trust', *Harvard Business Review*, March: 82–8.

JUC-SWEC (2006) *A Social Work Research Strategy in Higher Education 2006–2020*. London: Social Care Workforce Research Unit.

Lencioni, P.M. (2002) 'Make your values mean something', *Harvard Business Review*, July: 113–17.

Little, J.M. (2002) 'Humanistic medicine or values-based medicine … what's in a name?', *Medical Journal of Australia*, 177(6): 319–21.

Locke, J. (1974) *An Essay Concerning Human Understanding*. New York: Everyman Library.

Maben, J. and Griffiths, P. (2008) 'Nursing in society: starting the debate', *National Nursing Research Unit*. London: Kings College.

MacDonald, G. and Sheldon, B. (1992) 'Contemporary studies of the effectiveness of social work', *British Journal of Social Work*, 22: 615–43.

Mautner, T. (1997) *Dictionary of Philosophy*. London: Penguin Books, Blackwell.

McMahon, L. (2008) 'Reading the compass – a report on a workshop event on the leadership needs of the allied health professions', *LOOP*, London: City University.

National Council for Voluntary Organisations (2007) *NCVO's Response to the OTS Consultation on a new Third Sector Research Centre – November 2007*. London: NCVO.

NHS Education for Scotland (2008) *The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)*. Edinburgh: NES.

Olsen, D. (2000) 'Editorial comment', *Nursing Ethics*, 7(6): 470–1.

O'Neill, O. (2002) *A Question of Trust – The BBC Reith Lectures 2002*. Cambridge: Cambridge University Press.

Raths, L., Harmin, M. and Simon, S.B. (1978) 'Values and teaching: working with values in the classroom', in S.J. Robinson (2001) *Agape – More Meaning and Pastoral Counselling*, pp. 127–54. Cardiff: Aureus Publishing.

RCGP (2007) *Being a General Practitioner*. London: RCGP. Available at: www.rcgp-curriculum.org.uk/PDF/curr_1_Curriculum_Statement_ Being_a_GP.pdf [Accessed 1 December 2009]

Richmond, M. (1917) *Social Diagnosis*. New York: Russell Sage Foundation.

Robinson, S.J. (2001) *Agape – More Meaning and Pastoral Counselling*. Cardiff: Aureus Publishing.

Robinson, S., Kendrick, K. and Brown, A. (2003) *Spirituality and the Practice of Health Care*. Basingstoke: Palgrave Macmillan.

Russell, B. (1961) *History of Western Philosophy*. London: Routledge.

Sackett, D.L., Strauss, S.E. and Richardson, W.S. (2000) *Evidence-based Medicine: How to Practice and Teach EBM*. London: Churchill Livingstone.

Seebohm Report (1968) *Report of the Committee on Local Authority and Allied Personal Social Services*, London: Department of Health.

Sheldon, B. (1986) 'Social work effectiveness experiments: review and implications', *British Journal of Social Work*, 16: 223–42.

Sheldon, B. (2001) 'The validity of evidence-based practice in social work: a reply to Stephen Webb', *The British Journal of Social Work,* 31(5): 552.

Smith, N.K. (1929) *Immanuel Kant's Critique of Pure Reason*. London: Macmillan.

Talbot-Smith, A. and Pollock, A.M. (2006) *The New NHS – A Guide*. London: Routledge.

Thomas, M. (2008) 'Cognitive behavioural dimensions of a therapeutic relationship', in S. Haugh and S. Paul (eds) *The Therapeutic Relationship – Perspectives and Theme*. Herefordshire: PCCS Books.

United Kingdom Public Health Association (2007) *Climates and Change – The Urgent Need to Connect Health and Sustainable Development*. London: UKPHA.

Van de Luitgaarden, G.M. (2009) 'Evidence-based practice in social work: lessons from judgement and decision making theory', *The British Journal of Social Work*, 39(2): 243–60.

Webb, S.A. (2001) 'Some considerations on the validity of evidence-based practice in social work', *The British Journal of Social Work*, 31(1): 57–79.

Woodroofe, K. (1961) *From Charity to Social Work*. London: Routledge and Kegan Paul.