PROCESS AND SYSTEMS

What matters in acute care? Values and decision making in the acute medical unit

Author: Luke PJ Martin[A]

ABSTRACT

An acute medical unit (AMU) requires a broad range of decisions to be made under time pressure, where consensus is not always easily attainable. In such circumstances, having a clear and workable framework of values is of heightened importance in order to judge what course of action is best.

Within the NHS, a multi-value framework and a single-value framework have both been proposed in the last 10 years. However, it remains unclear what values currently guide the work of an AMU.

Data from a 16-month ward-based ethnography in an AMU in the north of England, supported by 27 semi-structured interviews, were analysed thematically in order to characterise a framework of values in decision making.

Within an AMU, people figure out what is best according to three values simultaneously: welfare, choice and effectiveness. These values operate as an irreducible triad, with implications for holism and realism in healthcare.

KEYWORDS: values, acute medicine, decision making, triad

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The value of values

Figuring out what course of action is best in clinical practice is becoming more demanding in two major respects. Firstly, as medical science and medical technology progress, so the number of available investigative and therapeutic options increases. Secondly, as cultural and ideological diversity increase, so the range of approaches to appraising any available course of action also expands. There are not only more pathways across the terrain of health and illness, there are also more ways of evaluating those pathways.

Putting these two trends together, contemporary healthcare professionals must not only be able to see a wide range of different courses of action, they must also be able to see a range of perspectives on the *same* course of action. They must see *different ways in different* ways. A clinician can be helped to navigate the different dimensions of decision making by becoming more conscious of values, which are already being incorporated into values-based prescriptive decision-making models as a way of complementing evidence-based medicine.[1] The most prominent of these models are values-based practice and values-based medicine.[2,3] While the precise nature of 'values' continues to evoke philosophical and sociological discussion.[4] A workable definition of values is that values are standards by which people judge what is good and bad. Within the NHS, 'values' have entered common parlance since the publication of Lord Darzi's 2008 report, *High quality care for all*.[5]

Values in the NHS

Lord Darzi lamented the lack of a shared vision for the NHS and recommended the establishment of an NHS Constitution to 'set out the purpose, principles and values for the NHS.'[5] This came to fruition in 2012, when the first version of the NHS Constitution was published, featuring seven core principles and six NHS values. These values 'provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS' and are listed in Box 1.[6]

The following year, Robert Francis published the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*.[7] Following a review of a broad range of professional guidance, Francis concluded that 'the overriding value of the NHS should be that *patients are put first* in everything done' [emphasis added].[7] In order to navigate the difficulties of the clinical terrain, Francis provided the clinician with a single compass: the best course of action can be identified by the fundamental NHS value: *patient centredness*.

However, such simplicity is only useful insofar as it is accompanied by clarity. What exactly is a patient-centred approach? What does it mean for a patient to be 'put first'? In terms of bioethical principles, does being patient-centred prioritise beneficence or respect for autonomy?[8] Despite its political endorsement, what remains 'lost in many of the discussions of

Box 1. NHS values

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Author: [A]higher specialty trainee in acute internal medicine, Northumbria Healthcare NHS Foundation Trust, Cramlington, UK and visiting fellow, Policy, Ethics and Life Sciences Research Centre (PEALS), Newcastle Upon Tyne, UK

patient-centered [sic] care … is the essential and revolutionary meaning of what it means to be patient centered'.[9] One weakness of the patient-centred approach is that it remains profoundly unclear how it translates to the care of a cohort of patients, whose needs are in competition for a limited supply of healthcare resources. This tension manifests on a daily basis within an acute medical unit (AMU).

Values in the AMU

Is discussing and completing a do not attempt cardiopulmonary resuscitation (DNACPR) order for this patient what is best? Is discharging this patient home today what is best? Is spending a short amount of time or a long amount of time with this patient what is best? Regarding everyday issues such as these, by what values can a clinician in an AMU figure out what course of action is 'best'? What matters in acute care?

Being efficient

The implementation of AMUs in UK hospitals was originally proposed as a means of improving efficiency at a time when the admitting medical team could spend as much time travelling to their patients as attending them; scattering newly admitted patients throughout a hospital was deemed ineffective and untenable.[10,11] The anticipated improvement in efficiency now has some empirical support. According to the limited evidence base, the primary benefit of an AMU is that it 'is associated with reduced hospital LOS [length of stay] compared to alternative models of care.'[12] This benefit can be termed 'efficiency' with an accompanying caveat: a reduction in length of hospital stay results from a range of factors (such as high-quality care, good communication and maintaining trust), not merely speed of activity; efficiency and haste are not entirely synonymous.

The importance of efficiency is reflected in broader guidance documents relating to AMUs; for example, the title of the report from the Acute Medicine Task Force features the need to get things right quickly: '*Acute medical care: The right person, in the right setting* – first time' [emphasis added].[13] Similarly, the NHS England publication, *Transforming urgent and emergency care services in England,* reflects this emphasis on urgency in its subtitle: '*safer,* faster, *better: good practice in delivering urgent and emergency care*' [emphasis added].[14] I list this literature in order to highlight a common theme: the workload of an AMU is intensely time pressured. Minimising time-wasting activity is, thus, of benefit to the health of the patient as well as the health of the hospital: a good course of action is an efficient course of action.

'Getting it right'

While the efficiency of care delivery may be the *raison d'être* of an AMU, there are indications that the work of an AMU is shaped by additional priorities, for which there is emerging empirical support.[15] For example, NHS England's guidance to urgent and emergency care services values cost-effectiveness, patient outcomes and patient safety; it is not mere speed that is prioritised, but care which is simultaneously 'safer' and 'better' as well as 'faster'.[14]

The triage function of an AMU is not intended to simply plan a patient's next healthcare destination 'first time' but also to ensure their healthcare needs are assessed correctly: 'the *right* person, in the *right* setting'.[13] This is in keeping with the NHS' recent cross-specialty programme, Getting It Right First Time, which seeks to improve quality and reduce costs by eliminating unwarranted variation.[16] Even in the pursuit of efficiency, this project endorses not mere decisiveness on initial assessment but getting it *right* first time. Thus, a good course of action in an AMU is not to be judged merely in terms of efficiency, but also in terms of clinical appropriateness; the responsible professional is not simply there to get the job *done* but to do the job *right*.

Promoting healing

Jocelyn Cornwell trained as a medical sociologist and ethnographer, and previously worked in NHS management. Her comments for The King's Fund relate primarily to an acute medical ward but relate also to an AMU where many of the pressures and complexities of ward-based care exist in a condensed form. She cautions against defining an acute ward in purely medical and organisational terms because 'When value is defined from the supply side alone, … it tends to ignore the relational and non-clinical aspects of care that are critical to patients' mental and emotional wellbeing and to their recovery.'[17]

Instead, Cornwell proposes that an acute ward 'would be better defined as a *place for healing*, … where pain and distress can be eased by caring professionals' [emphasis added].[17] Such experiential and relational aspects of care are not easily captured in quantitative metrics. As GP and scholar Kieran Sweeney said in interview prior to his death from mesothelioma:

> *Every patient that comes through a hospital is apprehensive. It's a strange place, you have strange sheets, you have odd tea in a plastic cup. The whole thing is vibrantly different.*[18]

Michael Wise was formerly a specialist in oral surgery and restorative dentistry before being admitted to an AMU with near-fatal sepsis.[19] Wise cautions that 'Further "efficiencies" are likely to result in degradation of acute services, not improvement.'[20] During his admission, Wise noticed that the pursuit of efficiency resulted in a compromise in communication: 'being busy can be used as an excuse for not being human, and there is a danger of this occurring among all frontline staff due to pressures.'[20] He calls for the priority of efficiency to be counterbalanced by concern for the smaller gestures of healthcare, which alleviate the distress and anxiety that accompany acute illness. As Cornwell illustrates:

> *Patients are inadvertently exposed to shame and humiliation; to distress, when their requests are ignored or overridden; to anxiety, about being kept in the dark, and about discontinuities and contradictory information; and to fear, when they are unable to trust caregivers.*[17]

This criticism ought not simply to be laid at the feet of healthcare staff. After all, the demands of working in the stretched and pressured environment of an AMU can result in staff also being exposed to shame, humiliation, distress, anxiety and fear. Rather, the insights of Cornwell and Wise illustrate that the cultural milieu of an AMU ought to supplement the pursuit of efficiency with a more relational priority: the promotion of healing.

In summary, the landscape of values in an AMU is explored but not understood; values have been identified but not yet unified into a framework. The territory is charted but unchartered. Just as NHS values cannot be reduced to a single value (such as patient centredness) without compromising clarity, so the values of an

AMU cannot be reduced to a single value (such as efficiency) without compromising care. The clinician is left with a fragmentary conglomeration of values without a vision of how to integrate them, a piecemeal mosaic of nothing in particular.

When faced with a clinical problem that requires a commitment to a course of action, by what values is a clinician to judge what is best?

A triadic framework of values

Methodology

In 2020, I completed a qualitative study of the role of values in decision making in an AMU in a hospital in the north of England. Over 16 months, I conducted approximately 216 hours of ward-based ethnography supplemented by 27 semi-structured interviews. As participant observer, I sought to obtain a thick description of the perspectives of staff, patients and relatives on the process of decision making in order to identify how values are involved.

Transcribed ethnographic and interview data were coded and analysed thematically, informed by the tradition of philosophical hermeneutics. A major concept within this tradition is the hermeneutic circle: there is interdependence between the whole and its parts, and between the object and the subject.[21] Measures were taken to optimise the trustworthiness of this reflexive account according to Lincoln and Guba's four-part framework of credibility, transferability, dependability and confirmability.[22] Approval for this study was granted by the relevant NHS trust and the Health Research Authority by 22 May 2017. Research presented here reflects a significant portion of a doctorate awarded by Newcastle University and sponsored by Northumbria Healthcare NHS Foundation Trust.[23] The scenarios that follow feature no personal data, and each participant has been assigned a pseudonym.

Findings

In the interests of being concise, the findings presented here seek to illustrate the operative values framework rather than establish it.

Within an AMU, people figure out what course of action is best according to three main values: welfare, choice and effectiveness. Appeal to these values is usually habitual and implicit when there is consensus regarding the best course of action. It is in times of conflict that the role of these values becomes more apparent. Rather than operating as three independent values, these three values seem to operate in synchrony as a triad. The values framework of an AMU is thereby neither simple nor complicated; it is complex. I present two clinical situations that illustrate this account of values.

Do not attempt cardiopulmonary resuscitation

Tony is an acute physician who was speaking with a patient, Mr Johnson, during the morning ward round. Mr Johnson was feeling breathless and had a background of advanced lung cancer. The conversation moved onto expectations for the near future and, specifically, cardiac arrest.

In this situation, Tony decided to complete a DNACPR order because, in his words, 'We've just got to be realistic … that we might not be able to cure everything here.' Speaking in interview afterwards, Tony's decision was justified in terms of welfare:

> *The alternative would be subjecting that patient to treatment, to [cardiopulmonary resuscitation], ventilation, whatever it comes to, that a reasonable body of medical opinion would say is inappropriate, unnecessarily aggressive and futile.*

However, Tony's welfare assessment entails an assessment according to the value of *effectiveness*:

Tony: 'If and when things take a turn for the worse, I think we shouldn't be trying to restart your heart.'

Mr Johnson: 'Shouldn't?'

Tony: 'It wouldn't work.'

Mr Johnson: 'That's nice to know.' [smiles – unclear if being sarcastic or relieved]

The concern that cardiopulmonary resuscitation (CPR) 'wouldn't work' is a concern that CPR would not be effective; Mr Johnson may not make it off the ventilator or may not make it home. As Tony explained in interview:

> *In my view, it would not be appropriate to put him on a life support machine … if he became so poorly that he needed organ support on a high-dependency or intensive care unit (if it got that point), the chance of him recovering to have what most patients would consider a meaningful existence (quality of life at home), the chance of him recovering would be pretty slim.*

It is noteworthy that Tony's welfare assessment also entails an assessment according to the value of choice. Namely, he anticipates what 'most patients' in Mr Johnson's circumstances would want.

In short, Tony's welfare assessment considers whether CPR would restore Mr Johnson to a state of flourishing or whether it would be unnecessarily aggressive and futile. However, in order to complete this evaluation, Tony relies on a preconception of what would be good in terms of effectiveness (would resuscitation work) as well as what would be good in terms of choice (would the outcome be desirable for a patient like Mr Johnson). In conversation with Mr Johnson, Tony figures out what course of action is best by appealing to three values in synchrony.

Discharge

Dr Taylor is an acute physician who was pleased that her patient, Brandon, was medically fit for discharge:

> *They spoke about his reason for admission, and how much better he feels now. Dr Taylor mentioned that, following pneumonia, it takes many weeks to recover strength, emphasising the need for rest.*

To her surprise, Brandon was reluctant to go home:

> *At this moment he became tearful and said he'd been having a lot of 'trouble with the neighbours'. He described it as escalating recently, and now the 'police are involved'.*

Dr Taylor summarised how she decided what course of action is best:

> *Before, I would have just sent him home. But now I wouldn't. He'd only re-present to [the emergency department], which creates a load more work. So, I tend to just let them stay another night.*

Dr Taylor's decision to extend Brandon's hospital stay was driven by a concern to do what is best in terms of effectiveness:

avoid creating a 'load more work'. However, in order to assess what course of action was most effective, Dr Taylor incorporated evaluations of the situation in terms of Brandon's state of health and Brandon's wishes.

Seeing as Brandon was recovering well, neither home nor hospital posed a threat to his health; both are acceptable courses of action in terms of welfare. However, such was Brandon's anxiety about going home that Dr Taylor anticipated he would choose to come back to hospital. This would divert hospital resources to his clerking and re-admission. Thus, in order to weigh up what course of action is best in terms of effectiveness, Dr Taylor relied on a preconception of what was best for Brandon in terms of welfare and choice. The three values are interdependent as a triad.

Discussion

Holism

Holistic healthcare is typically conceived as healthcare that tends to the whole set of needs of the whole patient, exceeding the boundaries of the reductionist biomedical model of disease.[24] This new empirically derived triadic framework of values in an AMU identifies another dimension: the whole set of values. When figuring out what course of action is best, only once the three interdependent values of welfare, choice and effectiveness are involved is the clinician on an AMU adequately appraising different ways in different ways.

The three priorities of an AMU in reviewed literature (being efficient, getting it right and promoting healing) correlate loosely with the three values (effectiveness, welfare and choice, respectively). To fail to appreciate these values as a triad risks the reductive consequences of one value predominating (Table 1); complexity of values is a precondition of holism in healthcare.

Realism

While I applaud the efforts of Lord Darzi and Sir Francis in bringing values to the fore of NHS literature, the weakness of both accounts of values is a lack of realism. Neither account is derived from a slow, immersive look at how values are involved in day-to-day healthcare delivery. As a result, both accounts land prematurely on a prescriptive account of values in the NHS, without due regard for how meaningful and workable such an account may be. A similar criticism can be levelled at the rapid and widespread endorsement of shared decision making as a prescriptive model of healthcare decision making. In short, Lord Darzi's many-value framework is too complicated and Sir Francis' single-value framework is too simple.

When figuring out what course of action is best in an AMU, the operative framework of values is neither single nor plural; it is triadic. This multifaceted framework of values in an AMU is perhaps unsurprising, given the multifaceted nature of an AMU itself. Simultaneously a professional arena seeking to get things right, a personal environment seeking to promote healing, and an organisational unit seeking to be efficient, the nature of an AMU is arguably already triadic. Welfare, choice and effectiveness form a triad of values that is a more realistic reflection of the complexity of working in an AMU by refusing to let a hospital bed be reduced to a bed of Procrustes.

This framework of values is not an algorithm to guide decisions, nor does it make difficult decisions easy. Rather, it is a means of articulating the multi-dimensionality of decision making in an AMU that is useful professionally, ethically and educationally by helping the clinician to see different ways in different ways. Insofar as the triadic nature of an AMU is shared by other healthcare domains, this empirically derived framework of values is a tool by which to realistically navigate the terrain of health and illness in other fields. While single-value accounts may be simpler than a triad, 'simple but unrealistic' is a luxury that practitioners, patients and providers simply cannot afford. ■

Table 1. Implications of value reductionism

Dominant value	Dominant priority	Dominant decision-making model
Welfare	Getting it right	Paternalism
Choice	Promoting healing	Consumerist liberalism
Effectiveness	Being efficient	Managerialism

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Address for correspondence: Dr Luke PJ Martin, Acute Medicine Department, Northumbria Specialist Emergency Care Hospital, Northumbria Way, Cramlington NE23 6NZ, UK. Email: luke.martin13@nhs.net