

Full Title: **Values based practice and authoritarianism**

Short title: **Values based practice and authoritarianism**

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Key-words (not appearing in title):

Particularism, principlism, proceduralism, Rorty.

Word count (excluding title page but including references):

~6,700

Character count (abstract):

Software used: Microsoft Word

Filename(s):

Values based practice and authoritarianism

Abstract

Values based practice (VBP) is a radical view of the place of values in medicine which develops from a philosophical analysis of values, illness and the role of ethical principles. It denies two attractive and traditional but misguided views of medicine: that diagnosis is a merely factual matter and that the values that should guide treatment and management can be codified in principles. But, in the work of KWM (Bill) Fulford, it goes further in the form of a radical liberal view: that the idea of an antecedently good outcome should be replaced by that of a right process. That however leads to a dilemma as to whether it can account for its own normative status. Given that difficulty, why might one adopt the radical version? I sketch a possible motive drawing on Rorty's rejection of authoritarianism which replaces objectivity with solidarity as the aim of judgement. But I argue that, nevertheless, this does not justify the rejection of the more modest particularist version of VBP.¹

Introduction

Values Based Practice (VBP) is a radical view of the place of values in medical practice. In this chapter I will first set out the steps one need to take to reach it and to highlight its radical liberal form in the work of KWM (Bill) Fulford. I will argue, however, that the radical version faces a dilemma when it comes to accounting for its own normative status. Given that difficulty, why might one adopt it? I sketch a possible motive drawing on Rorty's rejection of authoritarianism which replaces objectivity with solidarity as the aim of judgement. But I argue that, nevertheless, this does not justify the rejection of the more modest particularist version of VBP.

To begin with it will be helpful to have a contrasting view in mind whether or not it has ever been explicitly defended. (It is, in my experience, widespread among medical students at least.) On this traditional view, medical diagnosis is a matter of getting the facts right independent of any values. Values come into play in guiding – alongside good evidence based medicine – treatment and management. And when they do, they are codified in a set of principles, a proper understanding of which form a kind of moral calculus. The first two steps towards appreciating the radical status of VPB are recognising that it rejects both aspects of this traditional view. Values are implicated in diagnosis as well as treatment. And any moral principles to which we might appeal are insufficient. There is then a third step to which I will return shortly.

The main principles of Fulford's Values Based Practice are set out below [from Fulford 2004]. I will explicitly mention some of these – principles 1, 2, 5, 8 and 9 – in what follows.

Ten Principles of Values-Based Practice

- 1: All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis (the "two feet" principle)
- 2: We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (the "squeaky wheel" principle)
- 3: Scientific progress, in opening up choices, is increasingly bringing the full diversity of human values into play in all areas of healthcare (the "science driven" principle)
- 4: VBP's "first call" for information is the perspective of the patient or patient group concerned in a given decision (the "patient-perspective" principle)

¹ This chapter is based on my paper 'Radical liberal values based practice' *Journal of Evaluation in Clinical Practice* 17: 988-91. I am grateful both to its publishers for permission to develop further the material published there and to KWM (Bill) Fulford for his comments on that paper.

- 5: In VBP, 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 (the “multi-perspective” principle)
- 6: Careful attention to language use in a given context is one of a range of powerful methods for raising awareness of values (the “values-blindness” principle)
- 7: A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people’s values (the “values-myopia” principle)
- 8: Ethical Reasoning is employed in VBP primarily to explore differences of values, not, as in quasi-legal bioethics, to determine “what is right” (the “space of values” principle)
- 9: In VBP, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making (the “how it’s done” principle)
- 10: VBP, although involving a partnership with ethicists and lawyers (equivalent to the partnership with scientists and statisticians in EBM), puts decision-making back where it belongs, with users and providers at the clinical coal-face (the “who decides” principle)

Values are involved in diagnosis as well as treatment and management

The first step to VBP is to recognise that values are involved in diagnosis as well as treatment and management. Three main arguments for this claim are available. First, it helps make sense of the recent history of debate about the status of *mental* illness in which mental illness is compared either favourably or unfavourably with physical illness. Second, to an unprejudiced eye, pathology – mental or physical – is an evaluative notion. Third, attempts to reduce the concept of illness or disease (or even disorder) to non-evaluative notions have failed for principled reasons.

Fulford’s own influential argument for the first of these considerations runs as follows [Fulford 1989]. The key assumption that mistakenly drives both anti-psychiatry and biological defences of psychiatry is that *physical* illness is conceptually simple and value-free. This motivates anti-psychiatrists such as Thomas Szasz to compare mental illness unfavourably with physical illness [Szasz 1972]. But it also motivates defenders of psychiatry such as Kendell and Boorse to attempt to argue that mental illness is, like physical illness, value-free [Kendell 1975, Boorse 1975]. Without the first assumption, however, neither mistaken argumentative move is necessary nor justified. In setting out the consequences of this first claim – that physical illness is evaluative – Fulford draws particularly on Hare’s early work, especially his *Language of Morals*, on the logical properties of value terms [Hare 1952].

Hare pointed out that the value *judgments* expressed by (or implicit in) value *terms* are made on the basis of criteria that, in themselves, are *descriptive* (or factual) in nature. The value judgment expressed by ‘this is a good strawberry’, in one of Hare’s examples, is made on the basis that the strawberry in question is, as a matter of fact, ‘sweet, grub-free’. Hare then points out that where the descriptive criteria for a given value judgment are widely agreed or settled upon, it is these *descriptive* criteria that may come to dominate the use of the value term in question. This is a simple consequence of repeated association. In the case of strawberries, most people in most contexts value (prefer, like, enjoy) strawberries that are sweet and grub-free. Hence the use of ‘good strawberry’ comes to be associated with descriptions such as ‘sweet, grub-free, etc’ to the extent that it is this *descriptive* meaning that becomes dominant in the use of the term. This contrasts with, say, pictures where there are no settled descriptive criteria for a good picture because there is no general agreement about pictorial aesthetics. Hare’s general conclusion, therefore, is this: value terms by which *shared* values are expressed may come, by a process of simple association, to look like

descriptive (or factual) terms, whereas value terms expressing values over which there is disagreement, remain overtly value-laden in use.

This general claim applies equally to medical language. If illness (generically) is a value term, and if mental illness is more overtly value-laden than physical illness this is neither because (as Szasz argued) mental illness is a moral rather than a scientific concept, nor (as Kendell and Boorse argued) because psychiatric science is less advanced than the sciences in areas of physical medicine such as cardiology. Rather, Fulford argues, it is because psychiatry is concerned with areas of human experience and behaviour, such as emotion, desire, volition, and belief, where people's values are particularly highly diverse. Following the Oxford philosopher JL Austin, Fulford distinguishes between problems of definition and problems of use to suggest that, whilst at heart mental and physical illness are both equally definitionally complex, mental illness is more problematic in use because it reflects more problematic areas of human experience and behaviour, namely areas such as emotion, desire, volition and belief, in which people's values tend to be highly diverse. This line of thinking is reflected in VBP in the principle that: We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (the "squeaky wheel" principle).

Fulford then goes on to conduct an exercise in what another Oxford philosopher, Gilbert Ryle, called the 'logical geography' of medicine, of the given features of the uses of the medical concepts to justify this values-laden view of the subject. If medical terms are value terms, in Hare's sense, then many of the features of their use, including a detailed analysis of the many different kinds of disease concept, follow from the general logical properties they share with all value terms, combined, of course, with contingent features of human values (in particular the diversity of values in psychiatry).

But there is a second consideration to support an evaluative view of diagnosis. To an unprejudiced if at least inquiring eye, both the general concept of illness and specific instances of illnesses at least simply look to be evaluative. On the second point, John Sadler has devoted considerable care to detailing and taxonomising the values involved in the DSM IV codification of mental illnesses. He claims that psychiatry is thoroughly charged with values but, at the same time, it disguises or denies the role that they play. Thus one key aim of his book is to explore the multiple roles of values in a variety of different areas. These include broad themes such as the patient and professional roles, technology, culture and politics. But it also concerns more specific areas of psychiatric interest such as sex and gender and genetics. So if Sadler's piecemeal analysis is convincing then there is reason to believe that in mental illness, at least, values are widespread in diagnosis.

But on the more general point, Fulford's picture is sustained by the idea that there is more to pathology in general than what is unusual, for example. Illness is *bad* for us. So unless there is a way to explain away that apparently evaluative or normative aspect of illness, there is good reason to believe appearances. And, arguably at least, that is the case.

Merely statistical analyses of what is usual and unusual do not seem to capture the fact that high intelligence is in itself a good thing and low intelligence is a bad thing. More sophisticated attempts to use the notion of biological function have had the more modest aim of explaining away evaluative or notions from the concept of *disorder*, rather than illness or disease, conceding that the latter notions also contain the ineliminable notion of harm [Wakefield 1999]. But even with regard to that modest aim, it is far from clear that the notion of failure of function presupposed explains rather than smuggling in normative notions [Thornton 2000].

If this is right, then even if it were the case that the set of illnesses, diseases or disorders could be captured using merely factual criteria, this would only be because, contingently, we agreed about the underlying medical values. (In much the same way if the criteria for apples

which can be sold as fit for purpose are purely factual, this is because we happen to agree on which kinds of apples we like.) Such agreement may be merely culturally and temporally a local matter rather than answering to purely factual constraints about the nature of illness.

To summarise this first point, VBP is radical because it contests the idea that medical care is based on a value free diagnosis. Values are in play in diagnosis as well as treatment or management. Hence:

1: All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis (the “two feet” principle).

2: We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (the “squeaky wheel” principle).

Principles are insufficient for value judgements

The second step to articulate Values Based Practice is the rejection of both the sufficiency and the fundamental importance of moral principles in guiding medical practice. One reason for the first element of this is not as far from medical orthodoxy as it might appear but tends to remain hidden in medical ethical teaching [Thornton 2006]. It is implicit in the most influential recent approach to medical ethics: the Four Principles approach, a deontological or principles-based approach set out at length by Tom Beauchamp and James Childress in their *Principles of Biomedical Ethics* [Beauchamp and Childress 2001]. In it, the authors set out four general principles to guide medical ethical reasoning: autonomy, beneficence, non-maleficence and justice.

These four, which do not derive from any single higher principle, are supposed to capture medical ethical reasoning. They can, however conflict. Standardly, for example, beneficence and non-maleficence are in tension in both surgery and drug treatment. In psychiatry, in particular, autonomy and beneficence are in tension in the case of involuntary treatment. And thus an implicit part of the Four Principles approach is to frame ethical judgements which go beyond the resources of the principles alone.

Beauchamp and Childress describe two methods for dealing with such conflicts: specification and balancing. Specification is way of deriving more concrete guidance from the fairly abstract higher level principles. It is describe in outline thus:

Specification is a process of reducing the indeterminateness of abstract norms and providing them with action guiding content. For example, without further specification, do no harm is an all-too-bare starting point for thinking through problems, such as assisted suicide and euthanasia. It will not adequately guide action when norms conflict. [Beauchamp and Childress 2001: 16]

This looks at first to be a kind of deduction. Much as, once particular assumptions are made, Kepler’s Laws of planetary motion can be (more or less) derived from Newtonian Physics, so a specified rule can be derived from a higher level principle. And just as Kepler’s Laws are useful in the specific context of planetary systems so a specified principle – such as that doctors should put their patients’ interests first – can be tailored to give concrete guidance to cases of, for example, euthanasia. But although specification is some form of derivation, it cannot strictly be deduction because ‘specified’ lower level rules have more content, more information, than the principles from which they are drawn.

The second tool for generating an actual duty from apparently conflicting principles is more obviously not a matter of simply unpacking the principles. It is called ‘balancing’ and complements specification thus:

Principles, rules and rights require *balancing* no less than *specification*. We need both methods because each addresses a dimension of moral principles and rules:

range and scope, in the case of specification, and *weight or strength*, in the case of balancing. Specification entails a substantive refinement of the range and scope of norms, whereas balancing consists of deliberation and judgement about the relative weights or strengths of norms. Balancing is especially important for reaching judgements in individual cases. [ibid: 18]

Thus despite the emphasis on the importance of the four principles, Beauchamp and Childress do still suggest the need for a degree of non-principles-driven judgement explicitly in the case of 'balancing' and implicitly in the case of 'specification'. And thus even on this influential approach to medical ethics, the principles themselves are insufficient to guide practice. (That is why I stressed that there is no higher order principle. The view of which principle should dominate is not determined by the principles themselves but, somehow, from outside them.)

Values Based Practice goes further than this, however. Although it concedes that there can be sufficient agreement about some values that they can be codified to provide the basis for ethical codes and guidelines, these remain just a small part of the values that have to be taken account of in guiding medical practice which include individual preferences, desires, wishes, firmly held faith and convictions and so forth. By stressing this multiplicity, it stresses the standing possibility of disagreements and clashes in thinking about particular circumstances.

This contrasts with the way that even where there are well known clashes in the Four Principles approach, it is tempting to think that there are standard solutions. Thus, for example, the case of the Jehovah's Witness who competently refuses life threatening treatment is taken to exemplify the conflict of beneficence and autonomy and on the standard solution, autonomy is taken rightly to dominate [cf. Beauchamp 2003, Macklin 2003]]. (Things differ in the standard case of his or her young child.) The case is sketched in abstract and ideal terms and becomes, itself, a kind of rule to be applied to further actual cases. Competence in solving standard cases, in applying the principles and giving them standardly approved weight, becomes second nature to medical students keen to pass their ethics course and the element of individual judgement is downplayed.

So VBP makes explicit an idea implicit and often downplayed in conventional thinking about medical ethical practice, that there are diverse values in play and that attempts to codify them in principles are just a small part of the picture. Local context and individual preferences are the norm for VBP. Hence, the downplaying of principles-driven reasoning in the VBP claim:

8: Ethical reasoning is employed in VBP primarily to explore differences of values, not, as in quasi-legal bioethics, to determine 'what is right' (the 'space of values' principle).

Taken together with the claim that such values are in play in diagnosis as well as treatment, this is already quite a radical view of the place of values in medical care. But there is a third, and yet more radical step, implicit in principle 8 in the rejection of 'what is right'.

Radical liberal VBP

The yet more radical third step is what leads to principles 5 and 9:

5: In VBP, 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 (the "multi-perspective" principle).

9: In VBP, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making (the "how it's done" principle).

It picks up something that ought to have been a worry about the comments above about the

Four Principles approach to ethical judgement. I described it as a *deontological* or *principles-based* approach. But I then went on to suggest that, according to its own methods, the principles themselves are often insufficient for ethical judgement. Both specification and balancing require elements of judgement uncodified by the principles. Values Based Practice embraces this feature and suggests that principles only have a limited role, in cases where there is agreement in values. But this should prompt two questions: what governs ethical judgements when they are not constrained by principles? And, why is there ever agreement in values?

Before I address these questions on behalf of radical Values Based Practice, I will first outline a more modest answer. The more modest approach takes ethical judgements to be more like judgements of facts than they are like arithmetic judgements. Arithmetic can, at least arguably, be formalised in accordance with axioms and thus the correct answer to an arithmetic question can be determined or derived algorithmically from those first principles. This is the picture of moral judgement to which a full blooded principlist account subscribes. Moral judgements are determined by accord with principles. Those are what make such judgements true or false. But the Four Principles account does not seem able to live up to that because extra-principled forms of judgement enter through specification and balancing.

An alternative to principlism is particularism. Moral judgements answer to real moral features of the world: the moral particulars realised in specific cases. And thus one way to interpret the Four Principles approach is on these lines. The principles do not determine the correctness or otherwise of judgements, despite first appearances. Rather, they serve as useful reminders of the sort of things to take into account when thinking through particular cases. Further, when we agree about moral values, this can be because we are correctly responding to real features of the world in the way that agreement about factual matters can be partially explained by those facts themselves impacting upon us.

One might take this to be the way to think about Values Based Practice: modest particularist VBP [cf Thornton 2007: 49-88]. If so, it can accommodate Fulford's emphasis on the complexity of particular cases and the necessity to develop skills in responding to conflicting values. But this does not seem, at least to be Fulford's own view which appears to be rather more radical.

The clue to this is the claim that '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'. Now particularism would also reject the idea of a rule prescribing a right outcome (because it stands opposed to principlism). But this VBP claim seems to go further and to replace the idea of there being a correct outcome, something antecedently good, with a right process [cf Rubin 2008]. This thought is further reinforced by the claim that 'communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making'. Their role is substantive because the most there is of a good outcome is the use of a right process. It is not that the process is a reliable way to determine the antecedently real moral particulars. Rather, the process is the end itself. So in response to the question: 'what makes a value judgement true or false?', the answer seems to be neither accord with a principle or principles; nor accord with the real moral particulars; but rather, nothing further than competing views having been heard. So construed Values Based Practice is a radical liberal position.

In a previous paper, I put this point baldly thus: 'Fundamentally, all and any values deserve a hearing. All and any can be valued if they survive the right process' [Thornton 2011: 991]. That is to overstate the position. As Fulford pointed out in reply:

[T]he premise of values-based practice in and of itself sets limits to the values that are 'values-based practice-able'. Thus, racism, and any other form of discrimination,

as the NIMHE Values Framework makes clear, is incompatible in principle with 'mutual respect' and hence is by definition beyond the pale of values-based practice. Racism that is to say, is a value that, in Thornton's terms, doesn't even get as far as a hearing within values based practice; it never gets into the process at all. [Fulford forthcoming]

This picks up a claim that was already explicit in the 2004 paper 'Ten Principles of Values-Based Medicine'.

The shared values which, in VBM, are the proper remit of the rules and regulation of quasi-legal ethics, provide, for a given group, a framework for decision-making; Where values are not shared, VBM starts not from the post modern 'anything goes', but from a principle of *mutual* respect with a range of clear and definite implications for policy and practice (mutual respect, for example, precludes racism because racism is incompatible with respect for differences...) [Fulford 2004: 230]

In other words, Fulford has never claimed that VBP is purely procedural. It has always presupposed a framework of transcendental values, the values without which it would be impossible. But even this framework is deeply contingent. Fulford comments:

while people's values are highly diverse they are not chaotic. Values-based practice makes use of the (contingent) coherence of people's values to work within frameworks of values shared by the relevant stakeholder group [Fulford forthcoming]

If there is sufficient agreement in value judgements then codifications – whether ethical or legal or other – of them can be formulated. But such agreement is not explained as a response to real values 'out there' that command the agreement of right thinking people. The contingency is not merely that such value judgements are true (as empirical judgements can be contingently true) but rather, and more deeply, that there can be such agreement without the judgements answering to an antecedent notion of a good outcome.

This in turn suggests that there two kinds of value judgements in play: those that are presupposed by the process of VBP and those that are the outcome of it. But neither sort, even including the transcendental values, are objective or independent. Both gain the degree of validity they possess either directly or indirectly from the VBP process. But the fact that without the framework of transcendental values VBP would be impossible is not yet to say that those values are right. To make that claim would require independent purchase on the judgement that VBP is itself good. (Consider an anthropological inquiry of the values that underpin the Beltane fire festival, for example. It is possible that there are some transcendental values for such a practice, without holding which no agent would enact the practice. But identifying them need not commit the anthropologist to endorsing either the festival or the necessary underpinning values.)

This suggests a difficulty with the radical view, however. What is the status of the claim that: in VBP 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? Note first that although it says that conflicts of values are resolved... this is in the context of Values Based Practice. So it should be read as saying: conflicts of values *should* be resolved ... by processes designed to support a balance of legitimately different perspectives. But now we can ask, why should they? (It may be an analytic truth that they are within Values Based Practice, but we are invited to adopt this approach.)

The worry, now, is that this seems to be a value of a different order from the values that should be put through the right process of balancing views. It seems to be a higher order value, inconsistent with Values Based Practice's own approach. This then suggests a

dilemma for radical VBP. It can either address the question of why we should value values in the way it suggests, but at the cost of violating its own principles, or it can attempt no such question, in which case it lacks the prescriptive force that gives it teeth.

Authoritarianism

Given this objection to the radical liberal version of VBP, why not adopt the more modest position outlined before which accepts the first two features of VBP but rejects the third in favour of moral particularism? In my earlier paper, I commented of an explanation of agreement in value judgements as answering to independent value judgements that: 'That approach – particularism – perhaps smacks of authoritarianism and, in the context of medicine, recalls the dangers of totalitarian psychiatry' [Thornton 2011: 991].

Fulford agrees that this worry was indeed part of the motivation for rejecting the objectivist leanings of all of his commentators in the *Journal of Evaluation in Clinical Practice*:

Worse still, there are clear hints of totalitarian leanings (understood as commitment to pre-set 'good outcomes') in all three commentators' positions: Brecher's apparent endorsement of 'moral objectivism (p. 996) and later denial of patient choice (as 'saddling' the patient with responsibility, p. 997, see above), Hutchinson's advocacy of *Eudemonia* as 'the Good Life' (p. 1001, emphasis added but Hutchinson's capitalization), and Thornton's moral particularism [2, p. 991], all suggest, as Thornton alone acknowledges, authoritarianism. That may or may not be a 'good thing' in theory. But as Thornton reminds us, when it comes to practice, authoritarianism in the guise of totalitarian psychiatry (involving as it did the imposition of a pre-set view of 'good outcomes') was the basis of some of the worst abuses of medical practice in the twentieth century [Fulford draft reply]

The phrase 'imposition of a pre-set view of "good outcomes"' might carry either of two meanings, however. It might mean the imposition of a prejudiced view by powerful people. That would fit the label 'authoritarianism'. But it would not justify the rejection of the particularist in favour of the liberal view since the rejection of such a form of authoritarianism is consistent with a particularist picture of values.

Or it might mean that the process of deliberation of VBP answers to, is disciplined by, a, or the, good outcome, antecedent to and independent of the process. But if so, why think that responding to independently existing good outcomes is authoritarian? And can we understand VBP without 'authoritarianism'?

One motivation for that might be drawn from Rorty's assimilation of a rejection of a religious view of sin and a rejection of the view of empirical judgements or beliefs as picturing or representing the world. Rorty rejects both views as forms of authoritarianism in favour of pragmatism.

The pragmatists' anti-representationalist account of belief is, among other things, a protest against the idea that human beings must humble themselves before something non-human, whether the Will of God or the Intrinsic Nature of Reality. Seeing anti-representationalism as a version of anti-authoritarianism permits one to appreciate an analogy which was central to John Dewey's thought: the analogy between ceasing to believe in Sin and ceasing to accept the distinction between Reality and Appearance... To have a sense of Sin, it is not enough to feel guilty. It is not enough to be appalled by the way human beings treat each other, and by your own capacity for vicious actions. You have to believe that there is a Being before whom we should humble ourselves. [Rorty 2007: 257]

On this view, just as it is a sign of human maturity to reject religious authority in favour,

instead, of human agreement so it is also a sign of maturity a picture of judgements as answering to a non-human standard. John McDowell summarises the connection thus:

What Rorty takes to parallel authoritarian religion is the very idea that in everyday and scientific investigation we submit to standards constituted by the things themselves, the reality that is supposed to be the topic of the investigation. Accepting that idea, Rorty suggests, is casting the world in the role of the non-human Other before which we are to humble ourselves. Full human maturity would require us to acknowledge authority only if the acknowledgement does not involve abasing ourselves before something non-human. The only authority that meets this requirement is that of human consensus. If we conceive inquiry and judgment in terms of making ourselves answerable to the world, as opposed to being answerable to our fellows, we are merely postponing the completion of the humanism whose achievement begins with discarding authoritarian religion. [McDowell 2000: 109-10]

Rorty's view is motivated in part by a general criticism of the idea that empirical judgements and beliefs can represent the world, a criticism which dates back to his attack on the metaphor of the mind as a mirror of nature [Rorty 1979]. In more recent work this has led instead to the emphasis on 'solidarity' rather objectivity [Rorty 1991]. But even if one did not share his more general anti-representationalism, one might still think that value judgements, in particular, cannot represent a realm of independent values. One reason for that – with echoes of Rorty's work – might be the view that value judgements depend on contingent features of human subjectivity. It is only because of contingent features of our natures and cultures that we are in any position to make the judgements we do. Further, value judgements can be 'hard' in this sense: even having deployed very thorough argument and debate, there seems to be no guarantee of agreement. There are echoes of both of these two views in Fulford's radical version of VBP.

Thus, one way to motivate a rejection of authoritarianism in VBP, construed merely as the idea of being disciplined by some sort of right or good outcome, is to take note of the underlying contingency of value judgements and to conclude from this that the idea of objectivity in this area makes no sense. Such a view would have a precedent in Rorty's more general account of the metaphysics of human thought.

If so, however, there is an alternative to be found in what McDowell goes on to outline. The key idea is that neither the underlying contingency nor the idea that value judgements are hard rules out objectivity.

One aspect of the immaturity that Rorty finds in putting objectivity rather than solidarity at the focus of philosophical discourse is a wishful denial of a certain sort of argumentative or deliberative predicament. On the face of it, certain substantive questions are such that we can be confident of answers to them, on the basis of thinking the matter through with whatever resources we have for dealing with questions of the relevant kind (for instance, ethical questions)... But even after we have done our best at marshalling considerations in favor of an answer to such a question, we have no guarantee that just anyone with whom we can communicate will find our answer compelling. That fact - perhaps brought forcibly home by our failing to persuade someone - can then induce the sideways glance, and undermine the initial confidence. Rorty's suggestion is that the language of objectivity reflects a philosophical attempt to shore up the confidence so threatened, by wishfully denying the predicament. The wishful idea is that in principle reality itself fills in this gap in our persuasive resources. Any rational subject who does not see things aright must be failing to make proper use of humanly universal capacities to be in tune with the world. If we fall into this way of thinking, we are trying to exploit the image

of an ideal position in which we are in touch with something greater than ourselves – a secular counterpart to the idea of being at one with the divine – in order to avoid acknowledging the ineliminable hardness of hard questions, or in order to avoid facing up to the sheer contingency that attaches to our being in a historically evolved cultural position that enables us to find compelling just the considerations we do find compelling.

Here too we can make a separation. This wishful conception of attunement with how things really are, as a means of avoiding an uncomfortable acknowledgement of the limitations of reason and the contingency of our capacities to think as we believe we should, can be detached from the very idea of making ourselves answerable to how things are. We can join Rorty in deploring the former without needing to join him in abandoning the very idea of aspiring to get things right... [McDowell 2000: 112]

This suggests two ways of thinking about VBP and authoritarianism. One can reject authoritarianism, construed as a commitment to good outcomes independent of any particular instance of the process of deliberation, and put the emphasis on process or solidarity and motivate it by invoking something like Rorty's rejection of abasement to the 'Other'. One can appeal to this in the case of value judgements in particular because of their connection to the contingencies of human subjectivity and the omnipresence of hard judgements.

But, if so, one will need to shore up that picture against the objection that it does not follow from those motivations alone. That is, one can combine the first two elements of VBP, which I outlined at the start, with a denial of a constitutive role of process and maintain that even in VBP value judgements are disciplined by evaluative particulars. One way to fill this out is to borrow McDowell's own account in which the realm of values is in a transcendental harmony with our subjectivity [McDowell 1998]. That is, only those subjects with a particular kind of mind and life can have their eyes open(ed) to this tract of reality. (Thus the independence of the process or procedure of making value judgements and the values to which it answers is at the level of instances. In each individual case, the process may deliver the wrong judgement though as a whole, the process cannot in general deliver the wrong result.) Such an alternative is at least available to VBP at the cost of adopting, and defending, a particularist metaphysics of values.

Conclusions

I have set out two approaches to Values Based Practice and authoritarianism with their distinct philosophical costs. But there are reasons to favour the latter.

First, as I argued earlier, proposing or supporting VBP itself presupposes a value which does not seem simply to await the VBP process. (Nor would granting it a transcendental status help, a precondition *if* one wants to practice VBP, since that would still be contingent on that conditional.) Thus the value of VBP itself cannot be accounted for within VBP's resources if they are taken to exclude the idea of a good outcome, independent of a process of deliberation.

Second, as Fulford's fifth principle of Values Based Practice states: 'In VBP, 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 (the "multi-perspective" principle)'. But surely not just any balance would do? For example, a 'balance' imposed through undue force or influence by powerful parties to a clinical decision would not be a good outcome. So 'balance' is to be understood as something like the right or a good balance, which again seems to presuppose the kind of innocent authoritarianism in question.

Third, as Fulford often stresses, VBP involves the exercise of *skill*. But the clearest way to understand the development of such a skill involves learning how to achieve a good outcome in complex circumstances. This may well resist codification into an algorithm. It may involve sensitivity to context. But that is just to repeat a particularist rejection of principlism about value judgement.

Even if it is possible to position a radical, liberal version of VBP in the broader recent history of western thought, there remain reasons to prefer modest particularist Values Based Practice.

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