Radical liberal values-based practice.

Thornton, Tim

Thornton, Tim ORCID: 0000-0002-0137-1554 (2011) Radical liberal values-based practice. Journal Of Evaluation In Clinical Practice, 17 (5). pp. 988-91. ISSN 1365-2753

Full Title: Radical, liberal values based practice

Short title: Radical, liberal values based practice

Authors (i.e. name as it should appear on the paper):
Tim Thornton

Position (i.e. job description as it should appear on the paper):
Professor of Philosophy and Mental Health and Director of Philosophy

Address for correspondence:

University of Central Lancashire
Preston
PR1 2HE

Other Contact Details:
phone 01772895412
fax 01772892964
email:
TThornton1@uclan.ac.uk

Key-words (not appearing in title):

Fulford, evidence based medicine, particularism, principlism

Word count (excluding title page but including references):
~ 4,000

Character count (abstract):
~
Software used: Microsoft Word

Filename(s):

Radical liberal values based practice [1]

Abstract

Values based practice 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 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 it goes further in the adoption of a radical liberal view: that right or good outcome should be replaced by right process. I describe each of these three claims but caution against the third.

Introduction

Values Based Practice, VBP, is a radical view of the place of values in medical practice. In this commentary, I aim to set out the steps one needs to take to reach it and thus to highlight its radical status. My aim is more to rationalise the position than fully to defend it, however. I will reveal my own failure of nerve when it comes to endorsing the radical liberal version of the position. Modest VBP seems to me to be a more stable view.

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 – along side 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 also a third step, however, against which I will caution.

The main principles of Fulford's Values Based Practice are set out below [1]. I will explicitly mention some of these – principles 1, 2, 5 and 8 - 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)

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)

[1] This paper was written whilst I was a professeur invité at the Centre de Recherche Médecine, Sciences, Santé, Santé Mentale et Société, Université Paris Descartes. Thanks therefore to Pierre-Henri Castel in Paris and Christopher Heginbotham at UCLan.

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. The argument for this claim is threefold. 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 [2]. 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 [3]. 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 [4, 5]. 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 [6].

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. 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 Gilbert Ryle called the 'logical geography' of medicine, of the given features of the uses of the medical concepts to justify this value-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).

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 [7]. He claims that psychiatry is thoroughly charged with values but, at the same time, it disguises or denies the role that values 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 (including outside psychiatry) 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 [8, 9]. But even with regard to that modest aim, it is far from clear that the notion of failure of function presupposed explains, rather than smuggles in, normative notions.

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 step, 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 [10]. It is implicit in the most influential recent approach to medical ethics: the Four Principles approach, a deontologcal or principles-based approach set out at length by Tom Beauchamp and James Childress in their *Principles of Biomedical Ethics* [11]. 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 a way of deriving more concrete guidance from the fairly abstract higher level principles. It is described 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. [11]

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. [11]

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 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 Four Principles approach, which tempts us to think that there are standard solutions, even where there are well known clashes. Thus, for example, the case of the Jehovah's Witness who competently refuses essential, life-saving treatment is taken to exemplify the conflict of beneficence and autonomy and on the standard solution, autonomy is taken rightly to dominate [12, 13]. (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 Values Based Practice 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 is 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.

Radical liberal VBP

The yet more radical third step is what leads to principles 5 and 8:

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 [cf 14 pp49-88]. 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 particularism stands opposed to principlism). But this VBP claim seems to go further and to replace the idea of there being a right or good outcome with a right process [cf 15]. 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 right outcome is 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. Fundamentally, all and any values deserve a hearing. All and any can be valued if they survive the right process. If there is sufficient agreement about values then codifications – whether ethical or legal or other – can contingently be formulated. But the explanation for such agreement is not that there are real values out there that command the agreement of right thinking people. That approach – particularism – which I favour perhaps smacks of authoritarianism and, in the context of medicine, may recall the dangers of totalitarian psychiatry.

Conclusions

I have attempted to set out some of the key themes of Values Based Practice. It rejects both aspects of a traditional picture of the role of values in medicine. There is no value-free medical core. Even diagnosis is an evaluative business although, if we happen to agree on the values, we can fail to notice that fact. Further, evaluative principles are insufficient to guide value judgements. What principles there are do not go far enough to guide actual context-specific judgements with multiple legitimate perspectives. But further, the very idea that there is a right or good outcome is misleading. There is instead a concentration on balancing competing views in a market place of values: radical liberal VBP.

Such a view is not without its problems, however, and I will end by mentioning just one [cf 16]. 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.) And now the worry 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. This 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.

References

1 Fulford, K.W.M. (2004) Ten Principles of Values-Based Medicine. in Radden, J. (ed) The Philosophy of Psychiatry: A Companion. New York: Oxford University Press, 205-34

2 Fulford, K.W.M. (1989) Moral Theory and Medical Practice. Cambridge: Cambridge University Press

3 Szasz, T. (1972) The Myth of Mental Illness. London: Paladin

4 Kendell, R.E. (1975) The concept of disease and its implications for psychiatry.

British Journal of Psychiatry, 127: 305-315

5 Boorse, C. (1975) On the distinction between disease and illness. *Philosophy and Public Affairs*, 5, 49-68

6 Hare, R.M. (1952) The language of morals. Oxford: Oxford University Press

7 Sadler, J.Z. (2004) Values and Psychiatric Diagnosis. Oxford: Oxford University Press.

8 Wakefield, J.C. (1992) The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values. *American Psychologist*, 47, 373-88

9 Wakefield, J.C. (1999) Mental disorder as a black box essentialist concept. *Journal of Abnormal Psychology*, 108, 465-472

10 Thornton, T. (2006) Judgement and the role of the metaphysics of values in medical ethics. *Journal of Medical Ethics*, 32, 365-370

11 Beauchamp, T.L. and Childress, J.F. (2001) Principles of Biomedical Ethics. Oxford: Oxford University Press

12 Beauchamp, T.L. (2003) Methods and principles in biomedical ethics. *Journal of Medical Ethics*, 29, 269-274

13 Macklin, R. (2003) Applying the four principles. *Journal of Medical Ethics*, 29, 275-280

14 Thornton, T. (2007) Essential Philosophy of Psychiatry. Oxford: Oxford University Press

15 Rubin, J. (2008) Political Liberalism and Values-Based Practice: Processes Above Outcomes or Rediscovering the Priority of the Right Over the Good. *Philosophy Psychiatry and Psychology*, 15, 117-123

16 Gascoigne, N (2008) The value of ‘value’. *Philosophy Psychiatry and Psychology*, 15, 87-96