

TEN PRINCIPLES OF VALUES-BASED MEDICINE (VBM)

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Values-Based Medicine (VBM) is the theory and practice of effective healthcare decision-making for situations in which legitimately different (and hence potentially conflicting) value perspectives are in play.

As a theory, VBM is the values-counterpart of Evidence-Based Medicine, or EBM. VBM and EBM are both responses to the growing complexity of decision-making in healthcare: EBM is a response to the growing complexity of the relevant *facts*; VBM is a response to the growing complexity of the relevant *values* (see Principles 1-5, Table 1, and Table 2 below). As a practice, VBM is a skills-based counterpart of the currently dominant quasi-legal form of clinical bioethics. Quasi-legal ethics prescribes good *outcomes* in the form of increasingly complex ethical rules and regulations. VBM emphasises the importance of good *process* in the form particularly of improved clinical practice skills (see Principles 6-10, Table 1, and Table 3 below).

~ Table 1: Ten Principles of VBM, about here ~

Philosophy and Values-Based Medicine

VBM is derived primarily from philosophical value theory, ie that part of ethics (and of aesthetics) that is concerned with the logic, with the meanings and implications, of value terms (paradigmatically, good, bad, right, etc; and, in aesthetics, beauty). VBM draws on philosophical value theory particularly as developed through careful attention to language use [1].

Being an analytic rather than substantive branch of philosophy [2], philosophical value theory has in recent years been largely neglected in favour of ethical theories seeking to establish what for want a better word might be called moral "facts" [3]. The charge against philosophical value theory has been that, if not actually incoherent, it has little relevance to practical issues (Williams, 1985) [4]. Bioethics, similarly, while drawing extensively on substantive ethical theories such as deontology (in rights-based codes connecting ethics with law), consequentialism (as in health economics (Williams, 1995), and virtue theory (in professional education, eg May, 1994), has made little use of philosophical value theory. Yet it is precisely in being an *analytic* discipline that philosophical value theory is a potentially rich resource for an *empirical* discipline like healthcare [5]. In my *Moral Theory and Medical Practice* (1989) I showed how ideas derived from philosophical value theory help to transform the traditional fact-centred "medical" model of the conceptual structure of healthcare into a more balanced fact+value model. VBM is the practitioner's "cut" of this fact+value model of healthcare [6].

VBM: THE THEORY (PRINCIPLES 1-5)

As noted above, VBM stands to the values bearing on clinical decision-making much as Evidence-Based Medicine (EBM) stands to the facts (see Table 2). There is of course considerable debate, not least among those concerned with the development of EBM (Eddy, 1991; Hudson Jones, 1999; Straus et al., 1999), as to whether, in its current form, EBM is a sufficient response to the "fact" side of healthcare decision-making. A fact+value model, nonetheless, suggests that in the increasingly complex environment of modern healthcare, to the extent that we need EBM (albeit an enlightened EBM), so, too, do we need VBM.

Principles 1-5 of VBM thus define the theory of VBM as a values-counterpart of EBM. For Principles 1-3, as we will see, VBM and EBM run closely parallel. For Principles 4 and 5, VBM and EBM are anti-parallel, though still complementary (see Table 2).

Values and Clinical Decision-Making

1st Principle of VBM: All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis (The "two feet" principle)

The origins of VBM, then, are in the growing complexity of the values involved in all areas of healthcare decision-making. The most obvious evidence of this growing complexity is the recent explosion of ethical issues. But values come in many varieties, epistemic, aesthetic and prudential, for example, as well as moral and ethical; they also take different logical forms (eg needs, wishes, desires); they have many origins (eg personal, professional, cultural); and they have a rich grammar (encompassing nouns, verbs, adverbs, etc). Matters are further complicated by the fact that the very word "value", besides its central use of judgements of good and bad, has a number of other meanings [7].

VBM is concerned with values in healthcare in the central sense of the term, as covering any judgement of good and bad. A unifying feature of such judgements, as a former White's Professor of Moral Philosophy in Oxford, R M Hare, pointed out, is that they are prescriptive or *action-guiding* (Hare, 1952).

It is this action-guiding property of values which explains why values are one of the two feet on which all decisions in healthcare (and indeed in any other context) stand. All our decisions, conscious or unconscious, deliberative or reflective, are guided in part by matters of fact. EBM, as I noted a moment ago, is a response to the growing complexity of the facts guiding clinical decision-making. But values, too, are essential. We need facts to guide our decisions; but we also need values. This is illustrated by the relatively straight-forward decision about prescribing lithium given in Box 1.

~ Box 1: Diane Abbot's (Overtly evidence-based)
decision to start on lithium, about here ~

The importance of values in treatment decisions is relatively self-evident. The fact+value model of VBM, though, suggests that values are important also in areas of healthcare decision-making that, in the traditional fact-centred medical model, have been assumed to be exclusively matters for science, notably diagnosis. Principle 2 of VBM explains why this is so.

Values Visible and Invisible

2nd Principle of VBM: We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic. (The "squeaky wheel" principle)

Values are sometimes more and sometimes less visible in relation to healthcare decision-making. For example, values are highly visible in the current furor over whether cheap anti-AIDS drugs should be made available for developing countries. By contrast, values are more or less invisible in a "crash team's" decision over what drugs to use in a cardiac emergency.

The fact that values fall on a scale, from implicit to explicit, from invisible to visible, has led many to think of decisions in medicine as being divided into two distinct types, scientific and ethical. On this view, the anti-AIDS drug manufacturer's decision is a matter for ethics while the crash team's decision is a matter for science. It is on this view, too, that as noted at the end of the last section, treatment in general is considered a matter *inter alia* for ethics while diagnosis is considered a matter exclusively for science.

A different way of interpreting the visible/invisible scale of values, which again we owe to R M Hare and others in the "Oxford school", is that it is a function of *diversity*. Hare pointed out that where values are uniform, where they are largely shared, they tend to be implicit. It is only where values are *not* shared, where

different values are operative in a given context, that they tend to become visible (Hare, 1952; 1963). Thus, the crash team's decisions are driven by the shared value of saving the life of their patient. The furor over anti-AIDS drugs, by contrast, directly reflects a clash of clinical and commercial values. This is a case of what is sometimes said to be "the squeaky wheel getting the grease"! As Box 2 illustrates, it is only where values cause trouble, it is only when there is conflict or disagreement over them, that we notice they are there.

~ Box 2: Diane Abbot's (overtly values-based)
decision to stop lithium, about here ~

Hare's interpretation of the visible/invisible scale of values can now be applied to the relative visibility of values in relation to treatment decisions compared with decisions about diagnosis. In the traditional fact-centred model of medicine, as noted above, diagnosis is assumed to be essentially a matter for medical science. This is because in most of medicine diagnosis does indeed appear to be value free. But this in turn, according to Hare's interpretation, is because in the acute, life-threatening and often painful conditions with which medicine has traditionally been concerned, the operative values are largely shared. A "heart attack" (myocardial infarction), for example, involving as it does severe physical pain and imminent death, is, in and of itself, a bad condition by anyone's standards. Over such conditions, that is to say, our values are largely shared; hence they tend not to be problematic; hence, consistently with Hare's interpretation of the visible/invisible scale, the values involved in taking a heart attack to be a *bad* condition (and, hence, to this extent a disease[8]), go largely unnoticed. Yet the values are there, nonetheless.

The values involved in diagnosis come close to being fully visible in psychiatry [9]. Indeed, psychiatric diagnostic classification is more overtly value-laden than its counterparts in other areas of medicine in no less than four respects: 1) the language of psychiatry's official classifications such as the American *Diagnostic and Statistical Manual*, is value-laden, 2) some of the specific categories are defined in part by value judgements (eg personality disorders and the paraphilias), 3) the differential diagnosis of many psychiatric disorders includes moral categories (eg alcoholism v. drunkenness, psychopathy v. delinquency, hysteria v. malingering), and 4) Criterion B (social/occupational dysfunction) for schizophrenia, and corresponding criteria for other functional psychoses, are overtly evaluative in form.

The diagnosis of functional psychotic disorders makes fully explicit the need for a fact+value conceptual framework for diagnosis. What is required for a diagnosis of schizophrenia, say, is *both* the presence of certain specific experiences and/or behaviours (defined descriptively and listed under Criterion A) *and* a change in social and/or occupational functioning which is a change for the worse (defined by one or more of the negative value judgements specified by Criterion B). The same fact+value framework is implicit in all areas of medicine. In other areas, though, the evaluative element remains implicit because the operative values are largely shared. There is no 'Criterion B' for a heart attack, not because the diagnosis of a heart attack is *more* scientific than that of schizophrenia, but because a heart attack is *less* complex evaluatively. A heart attack, as described above, is a bad condition by anyone's standards. Hence the evaluative part of the diagnosis is unproblematic. Hence it can be (and properly is) ignored in practice.

In the traditional fact-centred medical model, the more value-laden nature of psychiatric diagnosis is taken to be a mark of the (supposedly) primitive state of psychiatric science (Boorse, 1976; Phillips, 2000). In the fact+value model supporting VBM, it is a mark of the evaluatively (as well as scientifically) more complex nature of psychiatry. Psychiatry, that is to say, and consistently with Hare's interpretation of the visible/invisible scale of values, is concerned with areas of human experience and behaviour, such as emotion, desire, volition and belief, over which human values vary widely and legitimately. This is why we need a Criterion B for the diagnosis of schizophrenia but not for a heart attack. Schizophrenia is evaluatively (as well as descriptively) complex. A heart attack is not.

More Science equals More Values not Less

3rd Principle of VBM: 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)

The "squeaky-wheel" principle, however, raises a question: human values, we must assume, have always been diverse. So why should it be only now, in the closing years of the twentieth century, that values have become so visible in medicine? From the perspective of the traditional fact-centred medical model, this is counter-intuitive. According to the traditional model, as science progresses so the importance of values in healthcare will become less not more. The fact+value model of VBM, by contrast, as we will see in this section, anticipates that as science progresses, so the importance of values in healthcare should become, as thus far they have become, more not less.

The increasing visibility of values in healthcare at this time is capable of different interpretations. Some ethicists and lawyers see it as a case of medicine finally waking up, or finally being woken up, to ethical issues: and about time too, is the implication! Hare's interpretation of the visible/invisible scale of values, however, that the degree to which values are visible is a function of diversity, suggests rather that medicine has been moving from a time when the operative values were shared to a time in which they are increasingly divergent. The growing visibility of values in medicine, Hare's interpretation suggests, reflects a growing diversity of the values guiding decision-making in healthcare.

So where has this growing diversity come from? We do not have to look far for possible candidates. First, there is the diversity of values themselves, noted above. Needs, wishes, interests, etc., may all be relevant to, and yet all pull in different directions in, medicine. Then again, there is the variety of origins of values: individual, cultural, professional. Again, these may pull in different directions. A third source of diversity, less well recognised but no less important, is the diversity of our values as individual human beings. For human values differ widely and legitimately, from person to person, for the same person in different contexts or at different times, from culture to culture, and at different historical periods (Fulford, Dickenson and Murray, 2002a).

These sources of diversity of values, however, are all largely static. Hence there must have been some other factor or factors involved in opening the stopcock, as it were, in letting the diversity of human values through into medicine at the present time. Again, we do not have to look far for likely candidates, some external and others internal to medicine. Externally, there is our increasing individualism (we are less inclined to take our values from each other), and our rejection of authority (of handed-down values). There is also global travel and communication (exposing us to a wider range of values) and our increasingly cosmopolitan society (bringing different cultural values into direct contact).

In addition to these external factors, however, significant as they have been, there is a factor of even greater importance which is internal to medicine, namely *scientific progress*. On the traditional fact-centred medical model noted above, this may sound a bit far-fetched, viz that scientific progress, instead of increasingly eliminating values from medicine, is actually letting them in. But the link between scientific progress and the growing visibility of values in medicine is in fact entirely straightforward. It is that scientific progress increasingly *opens up choices*, and with choices go *values*. So long as I have no choice in a given situation, my values are irrelevant. It is only where I *have* a choice that my values become relevant to guiding the choice I make. This is illustrated for psychiatry by the story of Diane Abbot, in Box 3. But in all areas of healthcare, technological and scientific advances are increasingly giving us an ever wider range of choices over an ever wider range of aspects of our lives [10].

~ Box 3: Science gives Diane Abbot choices, about here ~

Patient Centred Practice

4th Principle of VBM: VBM's "first call" for information is the perspective of the patient or patient group concerned in a given decision (The "patient-perspective" principle)

Thus far we have seen that values guide all decisions (Principle 1), that values become visible where they are diverse rather than shared (Principle 2), and that they are becoming increasingly visible in medicine because scientific progress, through opening up choices, is allowing the full diversity of human values into play in healthcare decision-making (Principle 3). In these three respects, as anticipated above, VBM runs parallel with EBM (see Table 2). We now come to two respects in which EBM and VBM, although still complementary, run anti-parallel.

The first anti-parallel between VBM and EBM is in their respective "first calls" for information. In EBM, our first call is objective information, ie information which is as free as possible from the particular subjective perspective of this or that individual or group. The aim of science, classically conceived, is what the American philosopher, Thomas Nagel, has called the "view from nowhere" (Nagel, 1986). This is why, in EBM, the information derived from meta-analyses of high quality research is at the top of the "evidence hierarchy" (ref [? Sackett, D. et al refsmain for their book on EBM]). Such information is as perspective-free as it is possible to get.

~ Box 4: Diane Abbot's values as the "first call",
in her decision to start lithium, about here ~

In VBM, by contrast, as Box 4 illustrates, our "first call" is the perspective of the particular patient (or group of patients) concerned in a given decision. This follows from the diversity of human values noted above. The point is that human values are not, merely, different but *legitimately* different [11]. Hence, in a given clinical situation, while we may have a great deal of general information about the values that are likely to be operative, and while such information is indeed an important part of the knowledge base of VBM (see Principle 7), it can never be a substitute for the *actual* values of the *particular* individuals concerned.

Resolving Differences

5th Principle of VBM: In VBM, 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)

Principle 4, in centring VBM firmly on the values of the person (or group) concerned in a particular decision, is, in this rather precise sense, "patient-centred" (Fulford, 1995). The diversity of human values, however, has a second and in a sense opposite corollary, namely that disagreements are *inevitable*. The given diversity of human values makes it inevitable that the values of a particular patient may well be different from those of their doctor; and both may be different from those of a nurse or social worker, or from those of the informal carers concerned, and so forth.

How, then, to resolve such differences? This brings us to the second anti-parallel between VBM and EBM. In EBM differences of view about the facts are resolved, in principle, by consensus: more facts (more data) are accumulated, crucial experiments are carried out, or a wider evidence-base is accessed, all with the aim of deciding which view is right. But when it comes to values, there may be no uniquely right view. And if Principles 2 and 3 of VBM are right, value diversity rather than uniquely right values, will become increasingly the norm in healthcare. Values-Based Medicine, then, aims to resolve differences, not by consensus but by what I have called elsewhere "dissensus" (Fulford, 1998), ie, by *processes which support effective action through a balance of legitimately different value perspectives*.

It will be worth looking at this notion of dissensus in a little more detail since it is at the heart of the practice of VBM. Thus, in the quasi-legal model of bioethics

differences of values are resolved, in principle, by reference to a rule (embodied in a code or guideline and often supported by law), which has been settled in advance by consensus. Differences of interpretation may arise, of course. But these are settled, again in principle, by reference to a regulatory body with executive decision-making powers [12]. Quasi-legal bioethics is thus outcome-focused. It seeks to determine the outcome of decisions by reference to rules expressing particular values. In this respect quasi-legal bioethics is like EBM. Both are outcome-focused. Both, that is to say, aim to provide rules (or guidelines) on what to do in a given situation. These rules are based on consensus respectively on the facts (EBM) and the values (quasi-legal bioethics) guiding clinical decision-making.

~ Box 5: Diane Abbot's values and the dissensual basis of her decision to stop lithium, about here ~

VBM, as Box 5 illustrates for the case of Diane Abbot, shifts the emphasis from outcome to process. In VBM there is a clear place for rules and regulation in providing a framework for practice. Such a framework, as we will see at the start of the next section, is essential. In VBM, though, the framework of rules and regulation is limited to those values which for a given community are largely shared, and hence over which consensus (agreement on a particular value) is appropriate. A key insight of VBM, however, summarised in Principle 3 above, is that, as scientific advances open up choices, so diversity rather than shared values will increasingly become the norm in healthcare decision-making. Increasingly, then, dissensual, as well as consensual, approaches to clinical decision-making will be needed. Increasingly, that is to say, instead of relying solely or even primarily on rules and regulation to prescribe outcomes, we will need to develop processes which allow effective decision-making through a balance of legitimately different value perspectives.

This 'multi-perspective' approach, in the context of healthcare decision-making, depends critically on a number of key clinical skills. This is one specific sense in which VBM is process rather than outcome focused. In VBM, good clinical decision-making, in the increasingly values-diverse context of modern healthcare depends, in the well-worn phrase, not just on *what* is done but on *how* it is done. It is to the skills base of VBM that we turn in the next section.

VBM: THE PRACTICE (PRINCIPLES 6-10)

As a strategy for resolving differences, dissensus, in VBM, is anti-parallel not only with EBM but also with bioethics. As a theoretical discipline, bioethics is a rich and varied discipline fully cognisant of the diversity of human values. In its connections with practice, however, it has taken a predominantly quasi-legal form premised on the (generally unacknowledged) assumption of "right values". The growing mountain of ever-more complex rules and regulations governing all areas of healthcare aim to give effect to these right values: the rules tell us what the values are; regulatory bodies have executive authority to interpret the rules in equivocal cases [13].

~ Table 3: VBM and Quasi-legal Ethics, about here ~

It is no part of VBM to suggest that we can do without rules and regulation altogether (Fulford and Bloch, 2000). To the contrary, as already noted, VBM incorporates rules and regulation but as a framework for practice defined by the values shared within a given community [14]. Such values, then, set benchmark outcomes against which decisions taken within the relevant community can be measured. By the same token, though, quasi-legal ethics is *inappropriate* in situations in which legitimately *different* values are in play [15]. In such situations, we should rely not on "good outcomes" but on "good process", not on *what* is done but on *how* it is done. The next four principles outline some of the key skills supporting the "how" of VBM.

Skills Area 1 - Awareness of Values

6th Principle of VBM: 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)

At the heart of many of the problems with values in healthcare is what might be called “values blindness”. Problems arise in practice, that is to say, not so much from direct conflicts of values as from a failure to recognise values for what they are. In multi-disciplinary teamwork, for example, a recent empirical study has shown that deep but largely unrecognised differences of values between psychiatrists, social workers, community nurses, patients and informal carers, may be a key factor behind failures of collaborative decision-making (Colombo et al, forthcoming; Fulford, 2001).

This “values blindness” has many sources: the tendency of values to become invisible when shared (see principle 2, above); the development of professional identity (which includes a shared value system, Fulford, 1994); and the success of science (tending to eclipse values and other humanities-related aspects of medicine, e.g. in medical education, Hope and Fulford, 1993).

A key skill underpinning VBM, then, is greater awareness of where, what and how values come into healthcare. Improved knowledge of values, and the reasoning and communication skills described later in this chapter, all contribute to this. A distinct skill, however, is greater alertness to language use, to the words and phrases actually used in a given context. This approach is based on the work of the Oxford philosopher, J.L. Austin (Austin, 1956/7). Austin argued for what he called “philosophical field work”, i.e. rather than just thinking about meanings in the abstract, Austin said that we should examine the language people actually use as a guide to understanding. This approach has been applied as a method of enquiry across a range of issues in the philosophy of psychiatry (Fulford, 1990), and, combined with empirical social science methods, in research (Fulford, 2001). It is illustrated for the case of Diane Abbot in Box 6.

~ Box 6: Awareness of the Values operative in
Diane Abbot’s case, about here ~

Recently this language-based approach has been developed as part of a new training programme in values-based practice for healthcare professionals (nurses, social workers, psychologists, etc) working in such areas as assertive outreach, community care and acute in-patient care. In this context, in particular, Austin’s methodology has turned out to be a particularly powerful method for raising awareness of the often very wide differences of values between different team members, and between providers and users of services (Fulford, Woodbridge and Williamson, 2002).

Having raised awareness of the extent to which values permeate healthcare, however, what is the next step? Where do we go from there?

Skills Area 2 - Knowledge of Values

7th Principle of VBM: A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people’s values (The “values-myopia” principle)

Where Principle 6 is concerned with values blindness, Principle 7 is concerned with “values myopia”, i.e. with our tendency, even when aware of values, to assume that other people’s values are the same as our own. Within healthcare this tendency is evident, for example, both in clinical interactions and, on a larger scale, in needs assessment (Marshall, 1994) and service planning (Campbell, 1996). But values myopia, as Box 7 illustrates, may have subtle and complex interactions with the evidence-base of practice.

~ Box 7: Knowledge of the Values operative in

Diane Abbot's case, about here ~

A second skill underpinning VBM is thus, straightforwardly, knowledge of the values bearing, or likely to bear, on a given decision in a given context. Our resources in this respect are partly empirical, partly philosophical. Empirical methods for gaining better understanding of other people's values include first hand narratives (the growing "user literature", for example), the use of poetry and other literary sources, anthropological methods (such as ethnography), psychological techniques (cognitive-behavioural; psychoanalysis), and surveys. Among philosophical methods, Continental philosophy, which is more text-based than Anglo-American Analytic philosophy, is a rich resource. This includes phenomenology (concerned with the structure and content of experience) and hermeneutics (concerned with revealing meanings) [16].

There is no shortage of methods, then, empirical, literary, philosophical, and so forth, for building up our knowledge of the values likely to be operative in a given case. In some instances this may be enough to resolve difficulties; greater knowledge of the values in play in a given clinical context may help to remove misunderstandings, to increase mutual respect, and so forth. To understand all is to forgive all! Sometimes, though, conflicts and difficulties will remain. It is here that reasoning skills may be helpful.

Skills Area 3 - Reasoning about Values

*8th Principle of VBM: Ethical reasoning is employed in VBM primarily to explore **differences** of values, rather than, as in quasi-legal bioethics, to determine "what is right" (The "space of values" principle)*

Methods for reasoning about values can be derived from any area of ethics (Dickenson and Fulford, 2000, chapter 2). Methods commonly used in healthcare include consequentialism (eg the utilitarian basis of much health economics) and deontology (eg rights-based documents; and standards). In the clinical context, two methods have gained wide currency,

- principles - "top down" reasoning from general principles
- casuistry - "bottom up" reasoning, direct from cases.

All of these methods may be helpful in VBM. The aim of ethical reasoning in VBM, however, is radically different from its aim in the quasi-legal form of bioethics (Fulford, Dickenson and Murray, 2002a). In quasi-legal ethics, as in legal reasoning itself, the aim is to decide "what is right". As noted above, this is appropriate where values are more or less shared. In VBM, by contrast, in the context of value *diversity*, the aim is rather to explore the nature and extent of *differences* of values. There are limits, of course, and these are reflected in the framework for practice provided by quasi-legal ethics and law (limited to situations where values are shared - see above, pxx). But in situations of value diversity the first aim of ethical reasoning is to explore the "space of values" (Fulford and Bloch, 2000).

~ Box 8: Reasoning about the values operative in Diane Abbot's case, about here ~

The radically different aim of ethical reasoning in VBM, ie to explore differences of values, has important implications for practice. These are illustrated by the case of Diane Abbot in Box 8. But it also carries with it a radically different way of thinking about differences of values themselves in healthcare. In quasi-legal ethics, the assumption of uniquely "right" values carries with it the implication that differences of values are a problem to be "solved" (by consensus, by *dictat*, or whatever means). The assumption in quasi-legal ethics is that differences of values are a barrier to effective clinical decision-making. In VBM, by contrast, differences of values, while indeed

sometimes requiring resolution, may also be a *resource* for clinical decision-making. For as management theorists rather than ethicists have recognised (Heifetz, 1994 [17]), we are all better at understanding other people's values when they are similar to our own. In VBM, then, different value perspectives, as represented by different members of a multi-disciplinary team for example (see below), operate as a series of lenses or filters for highlighting the often very different value perspectives of individual clients or patients. Different value perspectives within the clinical team, on this VBM model, far from being an impediment to effective clinical decision-making, offer a positive resource for matching decisions as closely as possible to the values of those concerned.

There will be situations, though, in which, despite being fully aware of the origin of a problem in differences of values (Principle 6), and despite having fully explored the values concerned (Principles 7 and 8), conflicts still remain. This is inevitable (and indeed to be welcomed!) if, as VBM suggests, *legitimately* different value perspectives are the norm in healthcare. In healthcare, moreover, matters can never be left in the air (Fulford, 1994). Practical situations demand practical action, even if this means leaving well alone. It is here that communication skills become important in VBM.

Skills Area 4 - Communication Skills

9th Principle of VBM: In VBM, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making (The "how its done" principle)

In VBM, awareness, knowledge and ethical reasoning are combined with communication skills to effect action. Educationally, this is an extension of a model of "ethics training" for medical students developed in Oxford, in which traditional ethics and law are fully integrated with communication skills in a clinical problem-solving approach to ethical reasoning (Hope, Fulford and Yates; 1996).

A wide range of communication skills are important in VBM. Two particular kinds of skill stand out, though, as being essential.

- *Patient-perspective skills:* ie., the skills of listening to and exploring the values of a client or patient. These are the basis of the patient-centred principle of VBM (Principle 4). Raised awareness (Principle 6), improved knowledge (Principle 7) and ethical reasoning (Principle 8) may all be helpful in this respect, particularly where there are difficulties of communication. But as Principle 4 emphasises, the values of the particular individual concerned are irreducible.
- *Multi-perspective skills:* ie., the skills involved in coming to a balance of values in situations of conflict and disagreement. These are the basis of the multi-perspective principle of VBM (Principle 5), the principle that replaces consensus with dissensus, ie., with effective action in the context of legitimately different value perspectives. Relevant perspectives in healthcare include those of other colleagues (medical and non-medical), of informal carers, of managers, and so forth. Mutual understanding and respect are fundamental in this respect. But specific skills, such as negotiation and conflict resolution, are also essential.

~ Box 9: Communication skills and the values operative in Diane Abbot's case, about here ~

Communication skills, although of course important also in quasi-legal ethics, have a deeper importance in VBM. In quasi-legal ethics communication skills are *executive*, their role being primarily to help in implementing the rules (which in turn are taken to express "right" values, see above). In VBM, by contrast, as

Box 9 illustrates for the case of Diane Abbot, communication skills have a *substantive* role. In VBM, communication skills are central, 1) to establishing the different value perspectives bearing on a given situation (complementing, at an inter-personal level, the philosophical and empirical methods outlined above under Principles 6 - 8), and 2) to resolving a course of action where the operative value perspectives are genuinely in conflict. This is why, as noted under Principle 5 above, in VBM good practice depends not just on *what* is done but on *how* it is done [18].

Taking back the territory

10th Principle of VBM: VBM, 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)

Where Principles 6-9 of VBM are concerned with the skills base of decision-making in the context of value diversity, Principle 10 is concerned with "who decides?"

In quasi-legal ethics, the assumption of "right" values, and its consequent proliferation of rules and regulatory authorities, inevitably leads to a model of the ethicist as an expert. And ethicists, like scientists, may indeed bring a range of relevant expertise to policy, practice, education and research in healthcare. As we saw earlier, however, where legitimately different values are in play, the particular value prescribed by a quasi-legal ethical rule, however enlightened, will necessarily conflict with the very different values of many of those to whom the rule is intended to apply.

The complaint of ethicists against doctors has been "doctor knows best". Bioethics has thus rightly emphasised the importance of patient autonomy in healthcare decision-making. Quasi-legal ethics, however, if extended from areas of value uniformity to areas of value diversity, risks a new culture of "ethicist knows best" (Fulford, Dickenson and Murray, 2002, Introduction). VBM, in starting from the legitimately different value perspectives increasingly in play in all areas of healthcare, puts ethical decision-making back where it belongs, with those concerned, as users and providers, as patients, professionals and as managers, at the clinical coal face.

~ Box 10: 'Who decides?' and the outcome in
Diane Abbot's case, about here ~

As the outcome of Diane Abbot's story (described in Box 10) illustrates, this re-engagement of those concerned with the decisions they make, is the basis of a close connection between VBM and the emphasis on agency which is at the heart of the recovery model of mental health practice (Mueser et al, 2002).

CONCLUSIONS - PSYCHIATRY FIRST

Although this chapter has been about Values-Based *Medicine*, the main driver for the development of the ten principles outlined here has been psychiatry. In one sense, this is how it should be. Psychiatry, as noted under Principle 2 above, is more value-laden than any other branch of medicine essentially because it is concerned with areas of human experience and behaviour in which human values are particularly diverse. Hence, it would seem, it is natural that it is here, in psychiatry, that VBM should be developed first.

In the traditional fact-centred model of medicine, however, the development of VBM in psychiatry would be interpreted very differently, viz as an apology or as a substitute for its (supposed) lack of a mature underpinning scientific theory. According to this model, as we also noted under Principle 2, psychiatry's more overtly value-laden nature is a mark of scientific deficiency. Correspondingly, therefore, according to the fact-centred traditional medical model, psychiatry

needs VBM because it lacks science. Philosophical value theory, by contrast, suggested that the more value-laden nature of psychiatry is a mark, not of scientific inadequacy but of values complexity. Psychiatry is more value-laden than other areas of medicine because it is concerned with areas of human experience and behaviour, such as emotion, desire, volition and belief, in which human values are highly (and legitimately) diverse (Fulford, 1989, ch 5).

It is as a response to value complexity, then, not as a substitute for scientific sophistication, that VBM has developed first in psychiatry. Principle 3 of VBM, furthermore, the "science driven" principle, showed that with future progress in medical science and technology, similar value complexity will increasingly become the norm in *all* areas of medicine. Far from lagging behind medical science, therefore, psychiatry, in developing the theory and practice of VBM, is providing a lead that other areas of medicine, under the pressure of scientific progress, will eventually be obliged to follow. VBM, then, is indeed a first for psychiatry. And given its origins in philosophical value theory, the extent of the penetration of VBM already into policy and practice in mental health makes it also a first for the *philosophy* of psychiatry.

Acknowledgements

I am grateful to the many colleagues who have contributed with suggestions, examples and case studies, to the development of the ideas set out in this chapter. My particular thanks go to Gillian Bendelow, Jeremy Dale, Melissa and Paul Falzer, John Geddes, Christa Kruger, Eric Matthews, Sarah Matthews, John Sadler, Werdie van Staden, and the members of the Values Project Group of the National Institutes of Mental Health in England (NIMHE), Piers Allott (Chair), Simon Allard, Catherine Laurence, Liz Mayne, David Morris, Albert Persaud and Kim Woodbridge.

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The Theory

1st Principle of VBM

All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis (the "two feet" principle)

2nd Principle of VBM

We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (the "squeaky wheel" principle)

3rd Principle of VBM

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)

4th Principle of VBM

VBM's "first call" for information is the perspective of the patient or patient group concerned in a given decision (the "patient-perspective" principle)

5th Principle of VBM

In VBM, 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)

The Practice

6th Principle of VBM

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)

7th Principle of VBM

A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people's values (the "values-myopia" principle)

8th Principle of VBM

Ethical Reasoning is employed in VBM primarily to explore differences of values, not, as in quasi-legal bioethics, to determine "what is right" (the "space of values" principle)

9th Principle of VBM

In VBM, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making (the "how its done" principle)

10th Principle of VBM

VBM, 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)

Table 1 : 10 Principles of Values-Based Medicine (VBM) [19]

| | VBM (Values-Based Medicine) | EBM (Evidence-Based Medicine) |
|--|---|--|
| PRINCIPLES OF VBM | SIMILARITIES | |
| 1. The "two feet" principle | Key role in clinical decision-making (the values in-put) | Key role in clinical decision-making (the fact in-put) |
| 2. The "squeaky wheel" principle | VBM a response to growing complexity of values | EBM a response to growing complexity of facts |
| 3. The "science driven" principle | Complexity (of values) generated primarily by scientific progress | Complexity (of facts) generated primarily by scientific progress |
| | DIFFERENCES | |
| 4. The "patient-perspective" principle | At the top of the "values hierarchy" are the value perspectives of individual patients of patient groups | At the top of the "evidence hierarchy" are facts which are as perspective-free as possible |
| 5. The "multi-perspective" principle | Disagreements over values are resolved primarily by processes which seek to balance legitimately different value perspectives | Disagreements over facts are resolved primarily by research methods aimed at establishing perspective-free facts |
| <u>TABLE 2: VBM and EBM</u> | | |

| PRINCIPLES OF VBM | VBM (Values-Based Medicine) | Quasi-Legal Ethics |
|-------------------------------------|---|---|
| 6. The "values-blindness" principle | Values important in all areas of healthcare | Values concerned with ethical issues |
| 7. The "values-myopia" principle | Full range of empirical methods used for increasing knowledge of values | Empirical methods subject to prior values |
| 8. The "space of values" principle | Ethical reasoning used to explore differences (the space of values) | Ethical reasoning used to decide "what is right" |
| 9. The "how its done" principle | Communication skills have substantive role | Communication skills have a merely executive role |
| 10. The "who decides" principle | Primarily patients and practitioners | Primarily ethicists and lawyers |

TABLE 3: VBM and Quasi-Legal Ethics

BOXES

Box 1 - Diane Abbot's (overtly evidence-based) decision to start on lithium

Diane Abbot, a 64-year old artist and art historian, was referred by her GP (family doctor) to a psychiatrist, Dr Kirk [20]. She had a history of occasional but increasingly disruptive episodes of hypomania. One of her academic colleagues had been successfully treated for a similar condition with lithium. She wanted to discuss the latest evidence on efficacy, on possible adverse side effects, etc., before deciding whether to start on lithium herself. The resources of EBM were essential to this process. Combined with Dr Kirk's individual expertise, and Diane Abbot's understanding of her colleagues' experience, the resources of EBM allowed everyone concerned to be satisfied that her eventual decision to start on lithium was securely evidence-based. But values, too, although not explicitly part of the decision-making process, were also essential. For without values those concerned would have had no basis on which to take a decision "on the evidence". In any decision about treatment, then, EBM is an increasingly essential resource. But it is the *values*, implicit or explicit, attaching respectively to clinical *effectiveness*, to *cost*, to *adverse* side-effects, and so forth, which have to be balanced in coming to a decision in a given case.

Box 2 - Diane Abbot's (overtly values-based) decision to stop lithium

A few months after starting on lithium, Diane Abbot returned to Dr Kirk with a letter from her GP explaining that she had decided to stop taking lithium. He, the GP, was concerned about this because her mood had been well stabilised and she had had no significant side effects "medically speaking". The implication was, could Dr Kirk make her see sense? Diane Abbot explained that although she had had no "real" problem with the lithium, and that although her mood had indeed been more stable, she could no longer "see colours". No, she did not mean colour blind! But colours had lost their emotional intensity, which, for her as an artist, was a disaster. She recognised her GP's concerns, which were indeed shared by her colleagues – that in her hypomanic episodes she risked embarrassing and potentially costly consequences of her disinhibited behaviour. But from her point of view, what mattered above all was her work as an artist. This was why she had decided to stop taking lithium [21].

Whereas, therefore, Diane Abbot's decision to start lithium (described in Box 1) was overtly evidence-based, her decision to stop lithium was overtly values-based. Both decisions, of course, on closer inspection, are seen to be based on facts (evidence) as well as values. In the present case, the relevant fact was that lithium was blunting Diane Abbot's appreciation of colour. There is evidence, from personal narratives (Jamison, 1996 as well as from wider field trials (Keller et al 1992), that a degree of blunting of normal mood is a common side effect of lithium. It is a side effect to which little attention has been paid because, to most people, it is relatively unimportant. Hence it did not figure in the evidence-based discussions which led to Diane Abbot's decision to start on lithium. Had Diane Abbot appreciated the extent to which lithium might impair her ability to "really see" colours, her values as an artist might have surfaced more explicitly at that stage. In the event it was only when her values led to her decision to stop treatment, it was only when her values thus became discrepant with those of her GP and colleagues, that they became fully visible. The same principle, of values tending to become visible only when they are discrepant, explains the overtly value-laden nature of psychiatric diagnosis compared with diagnosis in most areas of physical medicine (see text).

Box 3 – Science gives Diane Abbot choices

Diane Abbot's decisions were made possible by advances in the medical sciences underpinning psychiatry. Without the Australian psychiatrist John Cade's original observation of the mood stabilising properties of lithium, and subsequent studies clarifying its effects and side effects, Diane Abbot would not have been in a position to start on lithium. Equally importantly, though, without the availability of other options for managing her hypomanic mood swings, she might not have been in a position to stop taking lithium. Had her options been either to take lithium and to continue working albeit with less emotional intensity, or to stop lithium and risk potentially damaging periods of hypomania, she might well have opted for lithium. As it was, she worked out with Dr Kirk, her psychiatrist, an 'advance directive', which she agreed with her GP and colleagues, on the basis of which they could insist on early treatment with neuroleptics, if necessary as an involuntary in-patient, when she showed warning signs of a relapse. This was a feasible strategy in Diane Abbot's case because her warning signs were clear-cut, notably that she stopped sleeping and that she consistently misinterpreted these signs, at the time, as "entering a productive phase". But Diane Abbot's decision to stop lithium, nonetheless, was made possible, ultimately, by science. It was science which made lithium available and it was science which made the alternatives to lithium available.

The sciences, particularly the "brain" sciences, have had a bad press recently. For many in the user movement, indeed, there has been something of a moral imperative to refuse treatments, such as ECT, even where an individual has found such treatments helpful (Perkins, 2001). But as Peter Campbell, a user advocate who writes about his own experience of manic-depressive illness, has pointed out, what matters, is not that a particular treatment is or is not used. What matters is that the use or otherwise of a given treatment is guided primarily by the values of the person receiving it (Campbell, 1996). In psychiatry, as described in the text, the values guiding treatment decisions are necessarily diverse (i.e., because human values are inherently diverse in the areas of experience and behaviour with which psychiatry is concerned). But scientific progress,

in opening up an ever wider range of choices, is increasingly allowing the full diversity of human values through into clinical decision-making in all areas of medicine [22].

Box 4 – Diane Abbot’s values as the “first call” in her decision to start on lithium

Given the prominence afforded autonomy of patient choice in medicine, at least in industrialised countries (Okasha, 2000), it may seem self-evident that when it came to stopping lithium, Diane Abbot’s values should have taken precedence over those of her colleagues and GP. Importantly, though, her values were also the “first call” in her original decision to start treatment. Yet that decision, with hindsight, turned out to have been wrong, “wrong”, that is, as judged by her values as an artist. Had her need to be able to “really see” colours been more apparent at the time, then the evidence of lithium’s “emotional blunting” effects would probably have been discussed at that stage. Diane Abbot might still have decided to start on lithium; but with her eyes open to the possibility of this side effect; and with her GP, also, aware that this was a concern.

The skills which would have allowed Diane Abbot’s values to have been more accurately weighed in the decision to start on lithium are discussed below (under Principles 6-9). It is worth noting, though, that Diane Abbot herself was guided to a significant extent by the positive experiences of her colleague on lithium. So this is not a case of being misled by a naive use of EBM. Narrative, as well as meta-analytic, sources of evidence were in play. Yet still the wrong decision was made [23]. Things worked out well. But this was because of the way in which the subsequent decision to stop lithium was handled (see Box 5, below).

Box 5 - Diane Abbot's values and the "dissensual" basis of her decision to stop lithium

As noted in Box 2, and described in the text (under Principle 2), Diane Abbot's decision to stop lithium was overtly values-based because the operative values were contested. When she started on lithium her values were concordant with those of her GP and colleagues. But when it came to stopping lithium, what mattered to Diane Abbot was her ability to "really see" colours, while what mattered to her GP and colleagues was the potentially damaging effects of a further episode of hypomania. And her GP and colleagues had a point! Diane Abbot, when hypomanic, was a considerable liability to herself and to everyone else. Moreover, whatever her subjective impression, objectively her output as an artist had been enhanced rather than restricted while on lithium. Stabilising her mood may have taken some of the excitement out of her work; but this, in the view of her colleagues, was more than compensated for by her greater consistency. Even in her own terms, then, it seemed (to everyone else) imprudent, to say the least, that she should come off lithium.

Quasi-legal ethics and VBM, in these circumstances, lead to the same outcome, that Diane Abbot should stop taking lithium. But whereas in quasi-legal ethics stopping lithium is an outcome prescribed by a rule expressing a "right" value (patient autonomy), in VBM stopping lithium is the product of a process aimed at achieving a balance of different, and legitimately different, values. As described in the text, the quasi-legal rule is justified by a (supposed) consensus (on the value of autonomy); whereas the VBM process, of balancing legitimately different value perspectives, starts from the premise that there is often no one right perspective - hence the neologistic "dissensus". The shift in VBM from outcome to process, from *what* is done to *how* it is done, depends critically on the skills summarised under Principles 6-9 below.

Box 6 - Awareness of the values operative in Diane Abbot's case

As described in the text, a first, and essential, skill for VBM is raised awareness of values. The effectiveness of linguistic analysis, of careful attention to language use, as a method for raising awareness of values is illustrated by the account of the opening stage in Diane Abbot's story in Box 1. In the first part of this Box, Diane Abbot's overtly evidence-based decision to start on lithium was described in the language of a clinical case history. Here we were concentrating on the message, viz., the importance of EBM, combined with Dr Kirk's clinical experience and Diane Abbot's legal colleague's positive personal experience, as the basis of her decision. In the second part of the Box, by contrast, we were made aware of the significance of values, alongside evidence, in her decision. This was done by standing back for a moment from the message (the importance of EBM) and looking at the actual words in which the message (as a standard clinical case history) was delivered. The key words, italicised in Box 1, were *value* words - "effectiveness", "cost" and "adverse". The values awareness workshop and other new training initiatives, described in the text, are based on this linguistic-analytic approach.

Box 7 - Knowledge of the values operative in Diane Abbot's case

Knowledge of values in VBM includes knowledge both of the extent of the *differences* between people in their values and of the extent to which people *underestimate* these differences: we all tend to assume that other people's values are similar to our own. In Diane Abbot's case this "values myopia" (see text) led to one of the fault lines in her original decision to start lithium. The evidence-base for this decision, in so far as it was derived from EBM, was the effects and side-effects of lithium as characterised by the results of meta-analyses of high-quality research. But the effects and side-effects described in such studies are picked out by reference to values which are widely shared - an "effect" of a drug is one which is positively valued by most people in most contexts, a side-effect is one which is negatively valued by most people in most contexts.

There is nothing wrong with this as such. To the contrary, such values, positive and negative, are essential: they pick out, severally, variables (the effects and side-effects) relevant to a given research paradigm; and taken together, they determine whether the research is "worth" doing in the first place. But a failure to recognise the (inevitable and appropriate) skewing of research towards values that are largely shared, can lead to decisions which fail to reflect the sometimes very different values of a given individual in a particular context. The emotional blunting side-effect of lithium was known. But being a side effect of relative unimportance to most people, it had not figured prominently in EBM analyses of lithium, nor indeed in Dr Kirk's clinical experience. Hence, although emotional blunting turned out to be a key side effect from Diane Abbot's perspective as an artist, it was not on Dr Kirk's agenda in his initial discussion with her. Again, this is not a fault with EBM as such. Diane Abbot was equally misled by the narrative information from her colleague. The fault line runs rather from a "values-myopic" use of evidence, whether meta-analytic, clinical or experiential, in clinical decision-making.

Box 8 - Reasoning about the values operative in Diane Abbot's case

The fault line in Diane Abbot's original decision noted in Box 7, viz a values-myopic use of evidence, illustrates the key difference between quasi-legal ethics and VBM in their approaches to reasoning about values. The quasi-legal aim of coming to an agreement on the "right" outcome (consensus), inevitably leads to a focus on shared values. This is especially true of casuistry, or case-based reasoning, the very justification of which is that agreement on actual cases reflects shared values (Fulford and Bloch, 2000). Diane Abbot was, in a sense, guided in her decision to start lithium by casuistic reasoning, ie by the case of her colleague on lithium and his positive experience of that treatment.

The aim of ethical reasoning in VBM, by contrast, is to explore *differences* of values. In Diane Abbot's case, such reasoning might have alerted her, and Dr Kirk, to a key difference between herself and her colleague, viz that whereas she was a creative artist, he was a lawyer. Both were successful academics whose work required high levels of sustained attention. For both, therefore, the attention disrupting effects of hypomania were highly negatively evaluated. But whereas for the lawyer emotional blunting was *de minimis* (it was not indeed a side effect of which he had even been aware), for the artist it was of the essence. Casuistic reasoning, it is important to add, is not the only way in which this difference of values might have been anticipated. Principles reasoning, although much criticised in bioethics, offers a powerful tool for exploring differences of values [24].

Box 9 - Communication skills and the values operative in Diane Abbot's case

Both patient-perspective and multi-perspective communication skills, as described in the text, were important to securing the good outcome achieved in Diane Abbott's case. These skills were especially important at the apparently unproblematic initial stage, i.e. when everyone agreed with Diane Abbot's decision to start on lithium. A quasi-legal approach would have endorsed Diane Abbot's choice on grounds of the "right" value of autonomy. As such, there would have been a risk of alienating her colleagues and GP when her decision to stop lithium ran counter to their concerns for her welfare: such concerns, expressed in terms of beneficence in Beauchamp and Childress' *Four Principles*, tend to be relabelled pejoratively in quasi-legal bioethics as "paternalistic".

In VBM, by contrast, the dissensual nature of decision-making starts from (the meta-value of) respect for differences of values. A pre-condition of such respect is that the voices of those concerned, of *all* those concerned, are listened to. This is not as easy as it sounds! First, it is time consuming – although the time spent in coming to an understanding of the relevant perspectives tends to pay off in the longer term through those concerned, as in Diane Abbot's case, feeling understood and fully engaged (see Principle 10, below). Second, it is not always easy to understand other people's values where they are different from one's own. As noted in the text, this is one reason (among many others) why the different value perspectives represented by a well functioning multi-disciplinary team may be crucial to good clinical care. These perspectives operate as a series of "lenses" sensitive to the different values operative in a given case. A further and increasingly important series of such lenses is provided by support groups and networks of those with first-hand experience of the situation in question. Talking with people who have "been through it" provides invaluable experiential information. Diane Abbot's lawyer colleague was helpful to her not just in starting lithium but also in her decision to stop it. Given the differences in their values, though, it might have been helpful, too, if Diane Abbot had been able to talk to someone from the creative arts with personal experience of lithium therapy. A key role of advocacy groups in VBM is to support decision-making by helping to put service users with similar backgrounds and experience in touch with each other.

Box 10 - 'Who decides?' and the outcome in Diane Abbot's case

The shift in the locus of decision-making in VBM from ethicists and lawyers to patients and professionals, carries with it a shift from rights to responsibilities. The "right values" of quasi-legal ethics creates a culture of legal rights. The meta-value of respect for differences in VBM creates a culture of mutual responsibility. In Diane Abbot's case, Dr Kirk's failure to mention emotional blunting as a potential side-effect of lithium, might have led a rights-minded lawyer to consider an action for breach of duty of care. The action would probably not be pursued because the damages, in this case, were negligible. But an increasingly defensive approach to practice is the result of an over-reliance on such rights-based approaches. In Diane Abbot's case, the defensive strategy would have been to give her a checklist of potential side-effects of lithium and to ask her

to “sign” a consent form, or such like. Instead, a positive relationship of trust was built up, between all those concerned, such that Diane Abbot, her colleagues and GP, all felt engaged in and hence a sense of ownership of, the decisions made.

This had a number of positive therapeutic effects. First, the experience of emotional blunting helped Diane Abbot to appreciate that her mood swings were not, as such, pathological, but (within limits) a positive aspect for her work as an artist. Second, it allowed her to take responsibility (with help from others) for managing future over-swings. As noted in the text, her positive decision to stop lithium was combined with an advance directive for early intervention in a future hypomanic episode. This was felt to be important (by Diane Abbot as well as her GP and colleagues) because of her lack of insight in the past into the warning signs of a relapse. In the event, when these signs eventually recurred it was Diane Abbot herself who initiated contact with her GP. Somehow, her engagement in the process of managing her condition had given her improved insight at this crucial early stage. We can only speculate on the mechanisms involved here; some combination, perhaps, of her improved understanding of her condition, of her new trust in her GP, Dr Kirk and her colleagues, and of her confidence that she would be treated with due regard to her values. This improved insight may not prove to be a permanent change, of course. But her recognition of the positive as well as negative aspects of her mood swings, and her ability to take responsibility as well as to receive help, are consistent with the improved prognosis associated with recovery approaches to the functional psychoses (Mueser et al, 2002).

End Notes

[1] This approach, associated particularly with Oxford analytic philosophy, is sometimes called the "Oxford school". Exemplars include Philippa Foot (19xx [BILL TO ADD]; R.M. Hare (1952; 1963), J.O. Urmson (1950) and G.J. Warnock (1971). Although focusing particularly on moral values, philosophical value theory seeks to characterise the logical properties of value terms of all kinds. Von Wright defined several hundred kinds of values in his compendious, *The Varieties of Goodness* (von Wright 1963). In the current pandemic of ethical issues in medicine, we tend to forget that many other kinds of value bear on decision-making at all levels in healthcare, policy, managerial, clinical, and indeed in research (see Sadler, 1996; also chapter xx, this volume [Eds to ADD JZS chapter]). See also below Principle 1 below.

[2] eg a branch of philosophy that is concerned to clarify meanings rather than (directly) to produce "answers".

[3] See, eg, A. MacIntyre (1985) and J. Dancy (1993).

[4] I return to the practical importance of analytic ethical theory below, see especially footnote 11.

[5] of the contribution of mathematics to the physical sciences.

[6] The ten principles of VBM outlined in this chapter are based on Fulford KWM, *Values-Based Medicine* (forthcoming) Cambridge: Cambridge University Press.

[7] As when mathematicians speak of evaluating an equation, for example.

[8] The value judgements involved in taking a condition to be a disease/illness, etc., express not just negative value but a particular *kind* of negative value, ie disease is different from ugliness (negative aesthetic value), delinquency (negative moral value), foolishness (negative prudential value), etc. The characterisation of the particular kind of negative value expressed by disease, illness, etc, is an important task for philosophy particularly in relation to psychiatry: see my *Moral Theory and Medical Practice*, chapters 6-10, and work by the Swedish philosopher, Lennart Nordenfelt (1987), for one approach to this via agency. VBM, however, as presented here, is not dependent on this further characterisation. A negative value judgement, according to this approach, is at least a necessary, albeit not sufficient, prerequisite for a condition to be a disease/illness; and VBM is based on the generic properties shared by all value terms rather than the properties that mark out "medical" value judgements from value judgements of other kinds.

[9] See, Fulford, 1989, chapters 8 and 9; also 1994a. For an account of Criterion B for schizophrenia and the dependence of the differential diagnosis between psychosis and religious experience on value judgements, see Jackson and Fulford (1997). Values in the diagnosis of manic-depressive disorder are discussed in Moore, Hope and Fulford (1994). For recent work on values in psychiatric diagnosis, see the edited collection by John Sadler, (2002) *Descriptions & Prescriptions: Values, Mental Disorders, and the DSMs*; and his forthcoming monograph, *Values and Psychiatric Diagnosis*.

[10] Reproductive medicine is a case in point. Even a few years ago, reproductive medicine was concerned mainly with major pathology, like "impacted foetus" or infertility, over which people's values are largely shared (like a 'heart attack', these are *bad* conditions, in themselves, for anyone). But now a series of remarkable advances in "assisted reproduction" are giving us choices in areas that until recently were the stuff of science fiction: we can reverse the menopause, we can select foetuses, we are close to "designer" babies. Small wonder, then, that the full diversity of human values has been brought into play in this area of medicine!

[11] The central importance of individual perspectives as our "first call" in VBM is sufficiently grounded on the given diversity of human values in healthcare (illustrated by the edited collection, Fulford, Dickenson and Murray, 2002a). That our values are not only different but *legitimately* different also follows analytically from the logical separation of fact and value (or, more exactly, of description and evaluation) insisted on by "non-descriptivism" in philosophical value theory. The 18th century British empirist philosopher, David Hume, is generally credited with the first explicit account of the claim that no description of a state of affairs in the world can ever, in itself, add up to a value judgement of that state of affairs: "no ought from an is" is how Hume's "law" is often summarised. Hare is perhaps the clearest exponent of this position among twentieth century philosophers (Hare, 1952). The opposing school, descriptivism, points to situations in which we feel compelled to make a given value judgement on the basis of a given description (eg Warnock, 1971). Exponents of the Hume-Hare version of *non-descriptivism* argue that in such cases the "compulsion" to make a given value judgement is only a psychological not a logical compulsion. The compulsion, that is to say, arises from the fact that in response of the situation in question, most or even all people would in fact, human values being what they are, make the same value judgement. But this leaves the analytic separation (the separation of *meaning*) intact. In *Moral Theory and Medical Practice* (1989), and in two subsequent papers, *Nine Variations and a Coda on the Theme of an Evolutionary Definition of Dysfunction* (1999) and *Teleology without Tears: Naturalism, Neo-Naturalism and Evaluationism in the Analysis of Function Statements in Biology (and a Bet on the Twenty-first Century, 2000)*. I have argued that the Hume-Hare separation of fact and value applied to concepts of disease and illness has a rich crop of implications for practice in psychiatry and medicine. The phenomenology specifically of delusion,

furthermore, has interesting implications for the debate about fact and value in philosophical value theory. (The traditional debate has been in "horizontal" terms, ie directly between fact and value: the phenomenology of delusion, however, in particular that delusions may take the form of value judgements as well as of factual beliefs, points to a "vertical" connection between fact and value, ie that both depend on and hence are (logically) related through, a background structure of practical reasoning; see Fulford, 1989, ch 10). Many of the practical implications of philosophical value theory, however, can be derived equally from descriptivist theory, to the extent that healthcare is concerned with areas in which human values are largely *shared* (Fulford, 1991). The practical dangers of descriptivism arise from the temptation to extrapolate the claimed derivation of "values" from "facts" to areas in which human values are legitimately *different*. In such areas, ie in areas in which people's values are *not* shared, descriptivism is at risk of abusive consequences though imposing the values of one group or individual on those whose values are different. This risk is greatly increased through our tendency to underestimate the extent of the differences of values between us (see below, Principle 7). And it is a risk to which psychiatry, as an area of particular diversity of human values (Principle 3 above), has been peculiarly vulnerable in practice (Fulford, 1998). In psychiatry, through much of the twentieth century, abusive practices arose, not primarily from malicious intent but through one person or group's beliefs about "best" practice being allowed to exclude all other views (Fulford, 2000a and 2000b). In psychiatry, then, a non-descriptivist rather than descriptivist basis for VBM is required. VBM's Principle 3, furthermore, suggests that scientific progress is driving all areas of medicine increasingly into areas of value diversity. A non-descriptivist rather than descriptivist basis for VBM is thus likely to be increasingly important in all areas of medicine if we are to avoid the abusive imposition of one person's or group's values on others. See also Principle 10, below.

[12] In the UK, for example, the Human Fertilisation and Embryology Authority has such powers.

[13] It is no coincidence that the form of ethical regulatory codes is similar to that of practice guidelines derived from EBM. Both assume a unique 'right' answer (in principle) for every situation; both assume that we approximate to the right answer by consensus. Quasi-legal bioethics, I have argued elsewhere, has indeed adopted this model (unwittingly) from scientific medicine (Fulford, 2000b). In this respect, then, although developed originally as a guardian against the misuse of medical technology, bioethics has taken on the colours of its enemy!

[14] VBM, in emphasising value diversity, might be thought to risk ethical relativism and, hence, ethical chaos! There are several reasons why this is not so: 1) Human values, if more diverse than has generally been recognised, at least in healthcare, are not chaotic (if they were, law, which is self-evidently values-based, would be chaotic!); 2) 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; 3) 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 (ref [NIMHE Framework if adopted in time])). Far from being a recipe for ethical chaos, then, VBM is more like the values-equivalent of a political democracy. Like a political democracy, VBM might be thought to be weaker than an authoritarian autocracy, such as a monarchy or a totalitarian regime. And in situations of extreme danger (eg war or famine) an autocracy may be more effective (indeed we declare "marshal law" when a single shared value of survival is at stake). But the lesson of the twentieth century is that totalitarian solutions, in our civilisation, however well intentioned, collapse into abusive ideology; and that democracy, is, in practice, the stronger system (see also Principle 10, below).

[15] ie because the "right" values expressed in the rules and regulations governing the decision in question will necessarily be in conflict with the necessarily different values of many of those to whom the rules and regulations are intended to apply. See also below, Principle 10.

[16] Illustrations of each of these resources, empirical and philosophical, with practical relevance for healthcare, and drawing on a rich international literature, are given in an anthology combining first-hand narratives from patients and carers with academic articles, poetry and other literary sources (Fulford, Dickenson and Murray, 2002b). The aim of this anthology is two-fold: first, to illustrate the remarkable diversity of human values relevant to every aspect of healthcare decision-making (from first contact, through diagnosis to treatment and outcome); and second, to build up a picture of the extent of the arsenal of methods available for improving our knowledge of values in relation to health-care decision-making.

[17] Heifetz was a psychiatrist before moving into management and leadership studies. His book, *Leadership Without Easy Answers*, develops a theory of "adaptive work" supported by a series of clear practical strategies for effective decision-making in contexts of conflicting values.

[18] Exploring values may sound like a tall order (a luxury perhaps?) in the contingencies of day-to-day practice. But the practical importance of values in modern healthcare has been recognised in the UK by the priority afforded values in the work of the National Institute for Mental Health (England). The NIMHE is a department of the Modernization Agency in the UK's National Health Service (NHS) with responsibility for implementing the UK government's key strategy for mental health, the National Service Framework for Mental Health. The first action of the NIMHE was to establish a Values Project Group to develop a framework of values and, importantly, a "process for implementation" (Ministerial Announcement, 2001), for all stakeholders, both users and providers, in mental health. The Values Project Group is working in partnership with each of the

other NIMHE programmes, including such key areas as recovery practice, equality, inclusion and "users as experts". Its work is also connected with other NHS modernization initiatives, such as the Black and Ethnic Minority strategy [CHECK with Albert - due out March 10th]. NIMHE thus recognises that understanding patients' values and the values of colleagues is an *investment* in time. It is an up-front cost which could pay huge dividends in terms of the quality of the patient's experience, the job satisfaction of providers, compliance, responsiveness to change, and so forth.

[19] Adapted from Fulford, K.W.M. (forthcoming) Values-Based Medicine: Effective Healthcare Decision-Making in the Context of Value Diversity. Cambridge: Cambridge University Press.

[20] Diane Abbot's story is described in Fulford, forthcoming, Evidence-Based Medicine: Thomas Szasz' Legacy to Twenty-First Century Psychiatry (full ref to come).

[21] She was reluctant to experiment with lower doses of lithium (she had started at the bottom of the normal "therapeutic" range). Instead she worked out with Dr Kirk and her GP an advance directive for early intervention with further hypomanic episodes (see below, Box 3).

[22] The effect of scientific progress in opening up choices and hence bringing the full diversity of human values into other areas of medicine, is illustrated by a number of articles in Fulford, Dickenson and Murray, 2002b: see eg, J Raphael-Leff on gamete donation (Leff, 2002 [ADD from HEHV]) and Paul Cain on cardio-pulmonary resuscitation (Cain, 2002 [ADD from HEHV]).

[23] Or, more accurately, the right decision (to have a *trial* of lithium) on the wrong or incomplete grounds (because the possibility of emotional blunting had not been discussed).

[24] Tom Beauchamp and Richard Childress, in their original description of the role of principles reasoning in medicine (Beauchamp and Childress, 1989), are much closer to VBM than to quasi-legal ethics. Their "prima facie" principles are, in effect, dimensions along which the values operative in a given case can be analysed (Fulford, Dickenson and Murray, 2002).