# Debates in Values-Based Practice: Arguments For and Against

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# Editorial introduction

**Michael Loughlin**

Values-based practice (VBP) is an approach to managing conflict in values, initially developed by Professor K. W. M. Fulford in the context of the philosophy of psychiatry (Fulford, 2004) but designed to be applicable to a wide range of practice contexts in medicine, health and social care (Fulford *et al.*, 2012). It is founded on a recognition of a fundamental feature of the human condition: that all human practices are in some sense based on values[1] but that, for much of human history and for the foreseeable future, we are confronted with a plurality of values – people bring with them different commitments, goals, desires, interests and perspectives (including moral perspectives) when forming judgements about what it is reasonable to do in any given context.

Yet despite these sincere and often legitimate differences, people are required to work together to form common strategies for identifying and responding to practical problems. VBP is designed as an alternative to resolving differences by simple recourse to existent power structures – where some in positions of authority simply rule, then others follow the rule – or to some of the quasi-legal frameworks developed in contemporary bioethics. As a consequence, its advocates contend, its potential implications for practices within organisations are profound. It emphasises the development of reasoning and communication skills to enable all parties to a decision to recognise and respect divergent values, and to discuss their resolution in complex and potentially unique contexts. It has already won recognition in the British National Health Service, informing the Values Framework of the National Institute for Mental Health in England (2004). But the approach is by no means without its critics. Serious concerns about VBP have been raised by commentators in philosophy, psychiatry, public health and bioethics,[2] who subject to critical scrutiny its assumptions about value, rational decision-making, evidence, the political and organisational context of health care decisions and its relationship to dominant ideological assumptions and the economic status quo. In the process, these critics raise important and fundamental questions about how we characterise the problems currently facing health services, and how we think about rational decision-making and the limits upon it in the context of contemporary organisations.

This book aims to give voice both to proponents of VBP and to those raising serious concerns about its development and application. It also identifies two strands of thinking

[1] Though see below – even this apparently innocuous claim might need clarification if it is not to risk begging some important questions raised by critics of one of the forms of VBP discussed in this volume.

[2] Cf. *Journal of Evaluation in Clinical Practice*, 17(5), incorporating a full section on VBP (pp. 976–1001) with contributions from Fulford (2011), Thornton (2011), Gupta (2011), Brecher (2011) and Hutchinson (2011). For a discussion of the debate see also p. 844 of the editorial (Loughlin *et al.*, 2011) and for Fulford's response and further criticism see Fulford (2013) and Cassidy (2013).

representing different forms of VBP. While both recognise shared values in many practical contexts, Fulford and colleagues note that the essential values-component of decisions emerges primarily when differences in values come into play, and VBP is proposed as a practical approach to identifying and managing these differences. Another form of VBP is also designed to have practical applications, but it emphasises the need for shared values as a basis for coherent social practices, and is associated with a form of 'modest foundationalism' identified in the work of Professor Miles Little and colleagues working on values-based medicine (VBM) at the Centre for Values, Ethics and the Law in Medicine in the University of Sydney's School of Public Health (Little *et al.*, 2012; Little, 2013). This approach identifies foundational values and their different interpretations as having an explanatory role in practical dialogue, arguing that medicine survives as a social practice because it serves the foundational human values of survival, security and flourishing.

The book is called *Debates in Values-Based Practice* and is structured accordingly. In each of its two sections, a version of VBP is introduced by its leading proponent in the opening chapter, then subjected to a series of detailed analyses and responses – some supportive and others critical – in the ensuing chapters. The proponent is then invited to respond, to consider clarifying, or indeed modifying, the position in the light of the diverse and incisive arguments presented by the commentators. In addition to these concluding chapters for each section, the book contains a final chapter in which the designers of VBP and VBM attempt to draw together the key outcomes of their respective sections to discuss what they see as the crucial lessons to be learned, as well as the contrasts and comparisons between their approaches that the preceding debate has identified and challenged.

So the text can, of course (like any edited collection), be 'dipped into' – the reader may preferentially select specific chapters to suit her own interests, and each chapter is written in such a way that its intelligibility does not depend on having read the others. However, the book will be of greatest value to the reader who can follow the whole debate through its various stages. In so doing the reader is able to get a full sense of the different dimensions to the problems discussed and the (often unexpected) relationships between them. In particular, these exchanges bring out effectively the relationship between urgent practical questions concerning how we respond to the current problems facing contemporary health services, and fundamental and characteristically *philosophical* questions: about how we conceptualise 'value' and the relationship between value judgements and evidence concerning 'the facts'; and how we understand the relationships between health care provision and the broader economic, social and political environment, both nationally and globally. Differences are evident in the authors' philosophical starting points and the ways in which they characterise the true nature of the practical problem, and consequently the form that a proper solution would take. By the end of it, whatever her position on VBP, the reader will have acquired an overview, a map of the intellectual territory traversed in these exchanges. She can form her own conclusions about the validity of the criticisms and the adequacy of the responses, in the process gaining insight into a very current, very lively, on-going academic exchange about a set of issues whose urgent practical import seems undeniable.

My purpose in editing the volume was simply to bring together VBP's most prominent champions with those I regard as its most astute and insightful critics, and really just to 'see what happens'. The result is a text that I hope will appeal to a diverse group of

readers – a comprehensive investigation of the intellectual foundations and practical implications of VBP in the context of contemporary global health services. Primarily, the text should appeal to the growing numbers of academics working in ethics and applied philosophy (including health care ethics and medical epistemology), management and organisational theory, social policy, political philosophy and practice-based research. It will also be of interest to managers and practitioners in health organisations facing radically different internal and external environments, whose professional development requires them to seek out a fuller understanding of the problems that shape the work environment. But it has something to say to anyone with an interest in the on-going debate about values in health care, whether that interest is held as a patient (or potential patient), a member of the working population whose taxes fund health services or indeed anyone concerned with making a serious study of the problems of reasoning and decision-making in the modern world.

I have deliberately avoided using this introduction to the volume as an opportunity to state my own conclusions about VBP/VBM, as I think the value of the book is the insight it gives the reader into this on-going debate, and as noted the reader can judge the adequacy of the key protagonists' positions for herself. The brief overview of the arguments below is simply my effort to identify some patterns that emerge as the discussion progresses. It is obviously no substitute for the eloquent expression of those arguments by the contributing authors. The debate about VBP and (most importantly) the issues and conflicts it sets out to address, is by no means settled, and while this volume is a significant contribution to that discussion, none of its contributors would regard this as its conclusion – a point surely confirmed by the open-ended nature of the 'concluding' chapter.

## Practice, philosophy and the meaning of 'mutual respect'

So, then, what do proponents of VBP claim on its behalf? What are their assumptions and the alleged advantages of VBP to practitioners and patients? What motivates its critics and opponents? What do the two 'strands' of VBP/VBM have in common and what is the significance of their differences? What is the relationship between these and other academically inspired 'movements' aimed at improving practices within health care? Do we really need another approach or 'movement' to facilitate improvements in practice?

In the opening chapter of this volume, Bill Fulford explains and defends VBP, summarising 'the facts' regarding its development, intellectual starting point and applications. The chapter is very much his statement of what VBP 'is and isn't', reiterating the position in the way that Sackett *et al.* (1996) famously sought to 'clarify' evidence-based medicine (EBM) in response to diverse questions and criticisms. So Fulford restates the 'essentials' of VBP, including the foundational 'premise of mutual respect', the emphasis on learnable clinical skills, the relationship with EBM and the grounding of it all in 'a branch of analytic philosophy called ordinary language philosophy applied to the language of values'. This philosophical basis is contrasted to 'prescriptive' ethics, as its 'modest aim' is to clarify meanings, such that the premise of mutual respect is 'semantic' not 'moral': VBP provides a 'process' for balanced decision-making to serve the 'liberal' aim that competing voices be heard, a stance Fulford contrasts to 'the abuses of absolutism'. His chapter is very strongly supported by Ed Peile's ensuing discussion of values-based clinical reasoning. Writing as a doctor and medical educationalist, Peile argues that VBP 'stands or falls on its usefulness' and defends the utility of VBP, stressing the

centrality of the 'two feet principle' – that clinical decisions stand on the 'two feet' of evidence and values. Presenting a brief historical review of research into clinical reasoning, Peile explains and defends a crucial implication of this principle, and one welcomed enthusiastically in the chapters to follow even by authors otherwise critical of VBP: that values have an ineliminable role not only in the management of medical conditions, but also in their diagnosis.

Elselijn Kingma and Natalie Banner endorse Peile's assessment of the value of VBP as lying in 'its pragmatic as opposed to its philosophical aspects'.[3] They argue that the 'learnable skills' Fulford and Peile identify are extremely valuable, most notably the ability to recognise that '*particular features* of individual cases are deeply relevant to what is the right clinical path', such that 'even what appear to be minor or inconsequential aspects of situations can make all the difference in the decisions that should be made'; and, further, that 'particular features *differ radically* between different people'. The sort of training Fulford and Peile advocate should assist practitioners in identifying 'unexpected differences in desires, preferences, relationships, circumstances, emotions, evaluations of outcomes, responses to the world, interpretations of the world. . .' and in taking all of these factors into account in practical deliberations. However, they regard Fulford's claims about the philosophical basis for VBP as misleading and counter-productive. His efforts to 'ground' VBP in a form of 'ordinary language philosophy' that is contrasted to 'prescriptive value-theory' are, they argue, not only unnecessary, but actually detract from its practical value, because they commit VBP to philosophical claims that are deeply problematic.

The authors argue these points with great clarity, but one of these commitments is particularly worthy of attention here because it is taken up and examined in detail in several of the chapters to follow. The premise of 'mutual respect' plays a pivotal role in Fulford's account of VBP, acting as a constraint on which values may be included in the VBP process: values such as 'racism' are incompatible with mutual respect and are thus excluded. But when questions are raised about what other values are excluded, besides the rather obvious one of racism, the inherent unclarity of the term 'mutual respect' becomes apparent. Is the defender of female genital mutilation (FGM) excluded for having a value incompatible with mutual respect for women, or is the critic of FGM excluded for failing to show 'respect' for the cultural values of its defenders? Or are both these values to be treated as 'equal' in the VBP process, and each 'respected'? (In which case, a feminist might wonder why Fulford regards racist cultural values as 'beyond the pale' but does not feel the same way about sexist cultural values.) To explain what exactly we *mean* by mutual respect requires, Kingma and Banner contend, engaging in the sort of 'prescriptive' evaluative exercise Fulford claims VBP can avoid. It is as though he wants to present VBP as a kind of value-neutral mechanism, grounded in a philosophy that derives merely from an understanding of the meanings of ordinary words but which has, nonetheless, substantial implications. They note that it is unclear where this underlying value 'comes from': it seems to be a substantive value (as it is able to be formally incompatible with other prescriptive value-positions, such as racism) yet Fulford treats it as an 'analytic' premise, as though it derives from the meaning of ordinary language terms.

[3] This phrase is taken from their chapter, not Peile's: he would no doubt baulk at the words 'as opposed to' as it is not the goal of his chapter to critique Fulford's philosophical arguments, but simply to recommend VBP by focusing on its practical benefits.

The three chapters to follow present explanations of these features of Fulford's VBP with reference to the influence of an ideological framework identified variously as a form of 'radical liberalism' (in Chapter 4 by Tim Thornton), as 'neoliberal' (in Chapter 5 by Bob Brecher) and as a 'liberal deliberative democracy' (in Chapter 6 by Phil Hutchinson and Rupert Read). Thornton (along with Hutchinson and Read) welcomes enthusiastically VBP's 'radical' insight that diagnosis is a value-laden enterprise and not a 'merely factual matter', and (like Kingma and Banner) he praises its recognition of the centrality of the distinctive and particular features of real situations in decision-making, in opposition to a movement he represents as attempting to reduce decision-making to a deductive process based on principles. But Fulford's VBP contains, in addition, the idea that conflicts of values should be resolved not by 'a rule prescribing "right" outcome, but by processes designed to support a balance of legitimately different perspectives (the "multi-perspective" principle).' Thornton questions the status of this claim. While certain values (again, the only one explicitly identified is 'racism') are ruled out, and others are apparently ruled in, what matters in VBP is not finding the correct outcome but simply following the right process – within the range of 'legitimate' values (many of which may be mutually incompatible in practice) none is treated as objectively right or wrong, and the right outcome is, it would seem, whichever outcome emerges from the process. So why 'should' conflicts be resolved in this way? Does the word 'should' here have any prescriptive 'teeth'? In Chapter 1, Fulford asserts that it *does not*, nor can it, if VBP is to avoid 'the abuses of absolutism' – a term he appears to equate with what others might call moral objectivism, the view that moral claims can be correct or incorrect. Thornton argues persuasively that this version of VBP 'faces a dilemma when it comes to accounting for its own normative status'. Either it fails to account for the value of the process it prescribes, or it must 'violate its own principles' by accepting that moral judgements 'answer to real moral features of the world: the moral particulars realised in specific cases'.

Similarly, Brecher remarks that Fulford's dismissal of 'moral objectivism' as 'authoritarian' is self-defeating, because the rejection of the meta-ethical doctrine which allows for the possibility of making correct value judgements undermines every such judgement, including the condemnation of both authoritarianism and racism. This dismissal is, however, in line with Fulford's wilfully vague use of 'values', where the term is used as a cover word for 'needs, wishes, preferences' as well as for commitment to substantive evaluative positions including racism and anti-racism. For Brecher (reinforcing the concerns of Kingma and Banner) this vagueness allows VBP's exponents to present its underpinning values as 'in some sense neutral', 'self-evident' or 'sheer common sense', and therefore requiring no defence. This in turn allows them to regulate all other values, which by implication have the status of mere subjective opinion. In contrast to Kingma and Banner, Brecher doubts that VBP will have practical benefits. Citing earlier work in which he argued that the true role of 'ethical practice guidelines' was to formalise practical problems and so diminish the moral agency of practitioners, in the process transferring responsibility to practitioners for structural problems and thereby rationalising prevailing arrangements (Brecher, 2004), he depicts VBP as yet another mechanism invented by academics to allow organisations to 'manage' clashes of value. The management of clashes stands in contrast to the 'resolution', in any meaningful sense, of real problems, and such approaches typically 'undermine the critical moral reflection that is the essence of genuine moral deliberation'.

Hutchinson and Read argue that Fulford's VBP derives 'from a particular brand of liberal political theory: liberal deliberative democracy'. They regard this as a huge advance on alternative philosophical frameworks that have shaped approaches to problem-solving in health organisations in the past, but they note that ultimately Fulford's approach remains firmly within the 'dominant liberal paradigm'. The liberal conception of value reduces genuinely evaluative claims to mere 'expressions of individual preference', confusing the contentious with the purely subjective and translating the acknowledgement of value-pluralism into an implicit value-relativism. Citing Thornton approvingly, they state that liberalism 'somehow seems to think it has a right to help itself to a "master-value", which Fulford characterises in the rhetorically appealing language of "mutual respect". That really *is* a value, unlike the "values" that people hold.' They conclude that VBP is founded in a procedural conception of justice, claiming a spurious 'neutrality' between different value-perspectives while in fact involving a particular, and controversial, evaluative position. For these authors, the only way to 'resolve' value-conflicts is to acknowledge their status as real conflicts and then to try to work out which position in any particular conflict is the right one. They recommend a teleological approach to understanding value in health, which takes seriously the ancient concept of 'human flourishing' as the proper goal of clinical practice, and they readily acknowledge that this approach is contentious and requires argument – it does not assume the status of some sort of 'master-value' or neutral structure, beyond reasonable criticism.

We will return to this debate when considering Bill Fulford's response, which rightly focuses on the meta-ethical issue of the status of value judgements and the 'fact-value gap'. But it strikes me that one difference between the defenders and critics of VBP's liberalism may be the perspective authors implicitly assume when framing a 'practical' problem. If one starts one's thinking from the point of view of an individual, confronted with various possible value-positions and constrained by broader organisational, social, legal and other factors, then the first job of practical reasoning is to determine which value-position on the issue at hand is the right one. That will tell you which features of the situation, including the values of various parties, are 'problematic'. Consider the example of FGM, mentioned by Kingma and Banner. As an individual, confronted with a situation in which FGM features as an issue, I cannot begin to assess what the 'pragmatic' strategy is until I have worked out whether I regard FGM as a wholly unacceptable violation of the rights of women or as a cultural practice I may not 'like' but need to 'respect'. (Obviously I am not suggesting these are the only possible evaluations here.) Once I have determined my moral starting point, I must build in knowledge of the facts about my context – in what sort of society am I practising, are the laws and social conventions with me or against me? what are the beliefs and attitudes of the parties involved? and all manner of specific features of the situation at hand – in order to come to a view as to what course of action is the best one in context. The fact that some parties' values on this issue differ radically from my own is obviously a very important thing to know but it is not, in itself, an argument for regarding something I view as an atrocity as any more acceptable.

To generalise the point: for any 'conflict of values', it is only when one has formed a view as to where one stands that one can decide what is truly pragmatic, and which strategies represent the best ways to pursue what is the right outcome given the constraints of the context. One can then consider the possibility that sometimes the context makes a morally acceptable solution impossible – Brecher's point, noted above, that some problems are structural and beyond the scope of individual practitioners to resolve. Thus,

rigorous moral reasoning can enable us to identify problems requiring *political* solutions, in the form of radical organisational or social change.

However, if one approaches practical problems not from the perspective of an individual (as it were, in the first-person singular) but rather from what might be termed the 'first-person plural' perspective[4] of a policy-maker for an organisation or society, or the sort of working group Fulford discusses in Chapter 1 (deciding on its 'framework of shared values' within a remit set by its role 'at a particular time and within a defined context') then the fact that 'we' differ, often radically, in our value judgements, means that 'which position is right?' is automatically ruled out as a 'practical' question. The issue becomes which organisational and social structures and procedures we need to manage our differences as effectively as possible, and which differences we are going to allow to remain 'in play' (cf. Fulford's discussion in Chapter 1 of drawing up the Guiding Principles for the 2007 Mental Health Act, 'consensus' and 'dissensus'). From that perspective, the focus on 'process' over 'outcome' can indeed seem self-evident, as following from an understanding of the nature of practical reasoning.

Undoubtedly this reading has severe limitations, but it at least links the debates here about VBP's commitment to liberalism to the broader issues in political philosophy (such as the debate between Rawls and his critics, to which Brecher and Hutchinson and Read allude) from which the terminology of 'liberalism' derives its meaning.[5]

## Virtue, expertise and the social causes of illness

Mona Gupta's chapter takes us in a rather different direction, raising crucial questions about the relationship between VBP, EBM and clinical ethics. Picking up on Fulford's use of the terminology of decision-making 'tools', Gupta questions the extent to which VBP represents a clear and distinctive alternative to already established approaches in clinical ethics. She challenges Fulford to explain in more detail how precisely VBP operates 'in parallel with' EBM, looking at cases where this idea seems particularly problematic and noting VBP's apparent failure to interrogate the values underpinning EBM, which should not be seen as a value-neutral mechanism discovering 'the facts'. The chapter is pivotal in linking issues about the distinctiveness of VBP (raised by Kingma and Banner) with questions about 'upstream' values that 'lie behind frontline care, such as policy choices about the social determinants of health, or decisions about which agendas to serve in medical research' and possible directions in the future evolution of VBP (questions explored in ensuing chapters by Venkatapuram and Bluhm, as well Fulford and Little in their summary chapters). Following the chapter by Hutchinson and Read, her discussion of different ethical theories brings out a sense in which ideas set up in opposition in their chapter (their favoured, teleological approach, based on the idea of cultivating virtue and Fulford's emphasis on 'process' over 'outcome', the focus on 'how' rather than 'what' to do) could, in principle, be reconciled.

In Chapter 8, which develops a detailed analysis of a particular case involving a home birth, Richard Hamilton brilliantly draws together a number of concerns from the

[4] A phrase I have lifted from Fulford's summary chapter for Section 1.

[5] As noted, it is not the purpose of this editorial introduction to pronounce on the issues debated by the contributors, but I attempted to say something about background assumptions determining whom work in applied philosophy is 'for' in Chapter 6 of Loughlin (2002).

preceding chapters, exposing the weaknesses of paternalist, consumerist and principilist approaches to medical ethics, commending VBP's emphasis on a 'team-based model of decision-making' but defending 'an alternative Aristotelian model of collaborative medical decision-making'. Like Hutchinson and Read, Hamilton prefers an approach privileging the idea of cultivating virtue over 'respecting values'. In line with the criticism that VBP's radical liberalism actually undermines the most important advantages (both theoretical and practical) that VBP has to offer, he notes that there is 'a world of difference between insisting that the right answer to any moral problem is occasion sensitive and only available to the practically wise, and Fulford's "no right answer thesis".' Stripped of its 'unfortunate meta-ethical baggage', Fulford's VBP has the potential to cultivate practical wisdom, thus making an important contribution to improving medical decision-making.

Such claims might suggest that VBP can help to promote something like 'ethical expertise' or at least improved 'competence' in decision-making. Yet as Gideon Calder notes, the former idea seems wholly at odds with Fulford's 'democratic' and 'anti-authoritarian' leanings, and even the notion of ethical 'competence' is rendered deeply problematic by VBP's radical liberalism. In an impressively detailed analysis of different possible interpretations of ethical expertise and ethical competence, Calder aims to discover a version of ethical 'know-how' compatible with VBP and the idea that 'the handling of values' is a skill we can learn and, by implication, get better at as time goes on. Like *any* framework for practice VBP must, Calder argues, 'define what counts, or does not, as practice befitting the framework – and define competence as what counts as "good enough" in this respect'. The framework must be set up 'so that it is accessible and inclusive with regard to people arriving with different kinds of "baggage" in terms of their own values'. But there is a tension between this priority and 'the requirement to establish the values on which VBP itself depends. It is a tension between process and substance.' And it is on the side of VBP's radical liberalism that, Calder suggests, 'something has to give'.

This concern is reflected in Harry Lesser's call for VBP to specify more clearly which values need to be identified *in order to be rejected*. In a chapter rich in descriptions of cases and narratives, he notes that there are many values, held by patients, medical staff and other stakeholders, that are clearly 'unacceptable' and that to identify them we need a conception of the 'whole purpose of treatment' that, by implication, is not reducible to the expressed values of the parties involved. Lesser complicates the picture further with an extensive discussion of values that may not be openly expressed because they are unconscious, suggesting that people's accounts of their own values cannot be treated as authoritative. Echoing the concerns about structural problems raised by Brecher, he notes that the organisational context may impose values on practitioners that are 'social and political' in nature, including economic and legal restraints, and far from it being a requirement that we respect these constraints, it may sometimes be our duty to subvert them. This is a point developed extensively by Sridhar Venkatapuram, who notes that 'producing a site of exemplary deliberation and value management could be quite difficult if the surrounding environment is amoral or where values are deeply in conflict and contested'. Referring to the substantial and growing evidence-base regarding the social causes of illness, he challenges VBP to address directly the social and economic forces that determine health and shape the environments in which care is delivered and decisions about care are made. While 'concern about the surrounding social values that shape the clinical encounter is valid anywhere VBP is applied', he points out that it is particularly

pertinent when we consider the issue of 'global health': in the context of the developing world, the relationships between economic inequalities, levels of social development and the choices open to participants in the medical process are most apparent and most shocking.

Chapter 12 by Alistair Stewart draws together the questions and problems about when disagreements about value are 'legitimate', the role of political factors, the sense in which people's values are or are not knowable and sustainable and the value-laden nature of illness raised by authors throughout Section 1 of the book. Like Peile, Stewart writes as a practitioner, asking how precisely VBP contributes to his understanding of the problems he faces in his practice as a psychiatrist.

The sheer scope of the questions and criticisms raised across the section left Bill Fulford with a huge task in terms of providing a meaningful response within the limitations of its concluding chapter. Critics may feel that they have not been given a full answer to their wide-ranging and detailed criticisms, and to some extent Fulford would agree, as he does not see the role of his response as providing a resolution of all of the key controversies discussed in the section. He is concerned to address misconceptions about the nature of his project, including the idea that VBP is being advocated as some sort of 'competitor' to 'other ways of working with values in health care'. While he shares many of the commentators' concerns about overly simplistic or 'cut-price' versions of clinical ethics, Fulford stresses that he is not proposing VBP as a competitor to clinical ethics, but rather as a way of supplementing the best work in the area. He reiterates the partnership between VBP and evidence-based medicine, arguing that criticisms of EBM raised by authors in the section do apply to a 'cut-price' version of EBM – but he does not believe that the movement's founders, much less its prominent contemporary protagonists, are logically committed to this 'cut-price' version.[6]

Related to his explanation of the ways in which VBP works in partnership with both clinical ethics and EBM is his account of the development of the 'Lucerne protocol' – a reference to the time and place where his ideas on values, evidence and practice came together in the formulation of the position he was to characterise as VBP. Fulford endorses the view expressed by Hutchinson and Read that medicine as a practical discipline is not 'philosophy free', because practical disciplines are 'shaped by largely implicit conceptual frameworks'. He argues that making the frameworks explicit can allow us to work with them more effectively, and sometimes to change them. It was this conviction that led him to use ordinary language philosophy to clarify the relationship between evidence and values in health care. He outlines one particular line of reasoning to illustrate the dangers in the approach of Kingma and Banner, of disengaging the practical benefits of VBP from its philosophical underpinnings. His own application of ordinary language philosophy led him to appreciate both the role and limitations of casuistry in medical ethics. While the authors are right to point to the power of case-based reasoning, agreement about specific cases may reflect 'shared albeit implicit values', such that 'without an awareness of values the very effectiveness of casuistry in

[6] Several of Peile's examples (Chapter 2) are meant to illustrate the claim that VBP and EBM work together in practice, the former 'balancing' the latter. In particular, his illustration of the RCOG statement on C-sections implies that 'sometimes individual patient values must be given more weight than scientific evidence'. It is interesting to contrast this statement to Hamilton's example in Chapter 8, of the AMA statement in respect of an Australian woman requesting home birth.

driving agreement on cases puts it at risk of self-confirming bias'. So VBP needs cased-based reasoning, but case-based reasoning needs VBP if it is to avoid the pitfall of self-confirming bias.

He accepts that this is by no means the final word in the debate, and he offers what he calls 'promissory notes' regarding future work, that give us a sense of the future evolution of VBP in the light of the debates in this collection. In particular, more attention needs to be given to questions about the political and social factors framing decision-making in health (though he notes work already done on 'socio-collective' forms of VBP), on the concepts of expertise and competence in VBP, and on the debate about the meaning of 'mutual respect'. He describes this as his 'biggest personal learning point from the commentaries' and indicates that it is still his view that the premise ('mutual respect for differences of values') can be derived analytically from 'moves and counter-moves in theoretical ethics on the nature of values in general usually called the "is-ought" debate' – a claim he returns to in the book's concluding chapter, co-authored with Miles Little.

## Modest foundations

Miles Little's chapter on 'values, foundations and being human' opens Section 2 with an account of the thinking behind VBM, an approach developed as an extension of Fulford's work on VBP and grounded in axiology – the philosophical study of value. For Little, values are not preferences, but preferences may express values, and his key claim is that there are fundamental human values which form the basis of all coherent social practices. He identifies these 'foundational' (F) values as 'survival, security and flourishing'. Medicine survives as a social practice because it serves the foundational values. These values may be instantiated in different ways in different cultural contexts (he cites the differences between the health systems in the UK and the USA as one example) but he argues that these systems represent different practical expressions of the foundational values, and the different expressions can be socially analysed as reflecting different 'axioms': beliefs and commitments regarding the best ways to ensure 'maximum rates of survival, secure resources for those in trouble, and the capacity to restore the disabled to the potential to flourish'.

His position is called 'modest foundationalism': F-values are not foundational in the sense of being logically or epistemologically necessary, but rather they are 'end-points of iterative enquiry, a series of questions that keep asking for justifications until there is no answer except something like "Because that is the way humans are", or "Because societies can't function any other way."' Citing the great empiricist philosopher David Hume, Little notes that a line of enquiry about the value of a thing must end somewhere, in something that simply is desired for its own sake. So his conception of value is 'naturalistic'. F-values are 'descriptive and pre-normative'. This seems to contrast significantly with the position of Fulford, who has consistently rejected 'naturalism' and 'descriptivism'. We have seen that Fulford's only 'foundational' premise was, he maintained, 'analytic' in nature, not grounded in any empirical claims about what people 'just do' value. And if these F-values are shared by all human beings, from Albert Schweitzer to Josef Mengele, and underlie all human systems and practices, from the NHS to the slave trade, from the provision of child-care and old-age pensions to senilicide and infanticide, then how do they serve to explain, let alone help us resolve, the real differences about value that give rise to normative conflict?

For Little and his colleagues, the understanding that shared values underlie even serious and substantive differences can help us understand other parties and may contribute to a resolution or reframing of debates. The two chapters that follow his, both co-authored by Little's close collaborators Wendy Lipworth and Kathleen Montgomery, provide illustrations of the approach, firstly to analyse debates about the pharmaceutical industry and secondly about the emergence and shape of the medical profession. Divergent practices were, in their empirical work, discovered to be underpinned by 'more convergent, or at least recognisable, axioms', and awareness of this 'shared normative background' could, in principle, make discourse 'less antagonistic and more sophisticated'. In another apparent departure from the position of Fulford (but in line with Little's use of 'flourishing') the authors seem sympathetic to the 'virtues' approach to ethics, advocated by some of the critics of VBP contributing to Section 1, and which they found to be key to understanding the discourse of their subjects.

In a detailed and tightly argued chapter, Ross Upshur draws on his own extensive scholarship in medical epistemology to raise incisive questions about what, precisely, Little means by the terminology of 'foundations' and 'axioms'. Upshur has consistently argued that medicine does not need a 'base', 'rooted either in values or evidence'. He regards the language of 'foundations', even when qualified by the term 'modest', as at best misleading – implying a link to a 'totalising' explanatory project that is unsustainable given the evolution of medical practice – or as actually misguided. While there are a number of important 'regulatory ideals' regarding the significance of evidence, respect for certain values, respect for persons and respect for the choices and interests of patients, talk of 'basing' or 'founding' all practice in any of these ideals implies we can find, or should strive to find, some overall systematic account of their relationship that will be valid for all future practice. There is no reason to assume that this intellectual project could have any pragmatic or indeed explanatory value, as medicine is informed by a growing range of epistemic and normative sources, particularly 'given the forces of globalisation and the advent of concern for ecology and public health. . . These epistemic and normative sources are by no means completely aligned, aimed at the same ends or at the same stage of historical evolution.' Nor is there any reason ever to expect them to be. Upshur finds the idea of 'pre-normative' foundations deeply problematic given the vast diversity of human practices, and defends a fallibilist account of clinical reasoning that resonates with the casuist account, to be defended in detail by Mark Tonelli later in Chapter 19.

Aspects of that account are also evident in Andrew Miles' argument that while medicine must be 'informed' by a broad range of sources, including various conceptions of 'evidence' and 'values', it is a mistake to treat any of these sources as foundational, and that VBM is therefore a distraction from the project of integrating 'science and art, fact and value. . . in the service of medicine and humanity'. He regards his own conception of 'person-centred clinical care' as non-foundational, explaining this claim with reference to a meticulous discussion of the history of different forms of 'foundationalism' in philosophy, and coming to the conclusion that we can do no more (and no less) than conceptualise medicine as 'a human endeavour which draws necessarily on the multiplicity of medicine's knowledge sources, without being referentially harnessed to any single, privileged foundation'. Little's 'modest' version of foundationalism cannot, in principle, inform practice, as 'there is no non-arbitrary way of bridging the gap between the foundational values identified and specific decisions about real cases'. We can of course 'note' that different persons interpret F-values via different 'axioms', but these differences

may be radical indeed, and the approach leaves us with no way to say which practical interpretation is correct. So how it fosters rational dialogue, mutual understanding or any substantive conclusion is very unclear.

Mark Tonelli's chapter opens with a brief explanation of the casuistry he has defended for many years. In contrast to EBM, which he characterises as representing a more deductive approach, 'where the results of clinical research serve as the major premises from which conclusions about particulars are derived', casuistic reasoning focuses on the particular, and 'begins by asking whether and how a particular case differs from a standard, paradigmatic case'. Tonelli applauds the fact that both the forms of VBP/VBM discussed in this volume attempt to incorporate casuistry, but he laments the fact that, in Fulford's version, reasoning about values is treated as distinct from reasoning about evidence, 'with casuistry only applying to the former'. This perpetuates a false 'fact-value dichotomy' that distorts reasoning in real cases, where there is no necessarily clear divide between factual and evaluative aspects of a situation: 'casuistic reasoning on the part of clinicians can and should incorporate all factors relevant to a particular case in order to arrive at a recommendation or action, not just the values involved'. So by presenting VBP and EBM as addressing respectively each of the 'two feet' of clinical reasoning, casuistry is limited artificially to the 'values' foot. A more serious problem is presented by VBM's commitment to F-values, because casuistry, 'while clearly incorporating values, has no particular use for the foundational variety' and any attempt 'to place some values above others in a *universal* fashion... undermines the very notion of care focused on the individual.'

Robyn Bluhm's discussion of patient autonomy also finds the different versions of VBP/VBM inadequate, in isolation, to support a proper respect for autonomy, by which she means an idea of patient autonomy that goes beyond simplistic conceptions of informed consent on the one hand, and the unsustainable idea of privileging a patient's preferences over all other concerns. (She explains in some detail why these versions of 'autonomy' are inadequate.) Citing criticisms from Thornton and Brecher about Fulford's 'inclusive' use of 'value' to incorporate the preferences of a very broad range of parties, and a lack of clarity regarding the process employed to 'balance' all of these values, she then raises concerns that echo those of Miles regarding the gap between Little's account of F-values and decisions about real cases in health care. However, her conclusion is far more positive for VBP and VBM than those of the three chapters preceding her own: she finds that *in combination* the approaches of Fulford and Little complement each other in a way that enables them to incorporate a defence of the rich, philosophically adequate account of patient autonomy she presents. She explains how Fulford's VBP process, if modified by the incorporation of Little's foundational values, can provide a practical method for ensuring that a theoretically adequate conception of patient autonomy can be protected in clinical decisions.

In his summary chapter for Section 2, Miles Little obviously welcomes Bluhm's contribution and the empirical work of Lipworth and Montgomery in illustrating important practical applications of VBM. Rather interestingly, given the arguments about VBP and liberalism in Section 1, his response to Tonelli appeals to an idea associated with great liberal political thinkers such as John Rawls, that of 'wide reflective equilibrium'. For Little, VBM situates casuistry within a 'broader domain' incorporating 'previous moral experience, ethical learning, intuition, the details of context and the formal use of ethical structures (including casuistic reasoning) as fuel for reflective consideration.' So in

keeping with the methodology of his whole approach, Little is keen to point out the ways in which he and Tonelli are actually in agreement, and his more extensive response to Upshur similarly notes that he and Upshur are 'much closer in our positions than a reader of both chapters might assume'. Both Upshur's criticisms, and those of Miles, seem to assume that Little is 'doing epistemology' and that his use of the terms 'axioms' and 'foundations' must be read as *in some sense* an extension of the use of these expressions in the context of a justificatory exercise. But, he reiterates, his F-values are 'pre-normative': 'I am not trying to construct a rigid base or foundation for medicine's *knowledge*, nor for the details of its practice, nor its bioethics.' These 'foundations' are '*explanatory* in an aetiological or evolutionary sense. They are not prescriptive.'

This brings out another significant parallel between the debates of the two sections. Fulford's critics were puzzled by his insistence on a foundational premise that he deemed 'semantic' or 'analytic' – implying no substantive position in 'prescriptive ethics'. Little also denies that his 'foundations' have what Thornton would call 'prescriptive teeth', though for a different reason: that they represent not analytic but descriptive claims, albeit of a very general nature, regarding 'the way humans are'. These and other fundamental issues are returned to in the chapter Fulford and Little co-author, billed not strictly as a 'conclusion' but as their 'concluding reflections' on the debate thus far.

## Reflections, comparisons and prospects for evolution

That final chapter presents a comparison of the two approaches in the light of contributions to the book, reflecting on their similarities and differences and looking for 'practical pay-offs'. It is not like the conclusion of any other philosophy edition I have read. Consistent with their avowed methods, the authors do not attempt to 'resolve' all of the problems identified in the preceding chapters. While they bring out many significant points of comparison between the approaches, they also recognise a fundamental and irresolvable difference between the way they respond to what is termed in philosophy 'the fact-value gap'. As their whole approach is geared towards providing a basis for decision-making that throws light on the relationship between value judgements and the facts, one might assume that a fundamental difference in how they construe this relationship would raise serious problems for their claims about the compatibility/complementarity of their approaches. But instead they argue that 'the open and unresolved nature of the is-ought debate' is reflected in their differences and that it 'translates via their respective starting points into their complementary practical roles as decision support tools in clinical care'. Like the participants in the VBP process, they map out their shared framework assumptions, the complementary applications of their differences in emphasis and the elements of 'dissensus' that they are happy to live with, because in doing so they can find ways to address some of the practical problems the contributions to the volume have exposed. In particular, Little's foundational approach will, it is suggested, help Fulford's VBP to incorporate the sort of global concerns that need to be addressed if VBP is to maintain its relevance in the light of considerations of the social and economic causes of morbidity and mortality globally. But they reflect on other potential developments in the evolution of their combined approaches and they conclude by celebrating 'the new community of ideas' brought together in this book, seeing the process of debate as inherently valuable in stimulating new ways of thinking about the real and important problems the respective chapters address.

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