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CHAPTER 18

From bioethics to values-based practice

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In this chapter we begin the process of building up the toolkit for tackling problems of values in mental health.

We start by outlining three important methods of ethical reasoning widely used in bioethics—principles, casuistry, and perspectives. We review the strengths and weaknesses of these methods, for health care generally in Session 1, and specifically for mental health in Session 2. Session 3 moves on to some of the main schools of general ethical theory—deontology, consequentialism, and analytic ethics—again looking at their strengths and weaknesses both generally and in relation to mental health. The last of these, analytic ethics, leads, finally, in Session 4, to the theory and skills base of values-based practice (VBP).

Session 1 Bioethics and health care

The main purpose of this session, then, is to introduce three approaches to ethical reasoning widely used in bioethics, principles, casuistry (or case-based reasoning), and perspectives, and to consider the pros and cons of these approaches as measured against the four practical objectives of training in ethics outlined in Chapter 17, awareness, attitudes, knowledge, and thinking skills.

In order to set what follows in context, however, we will start by considering three questions about bioethics itself: (1) What are its historical origins? (2) How should we understand its aims? (3) What have been its outcomes?

Bioethics: origins, aims, and outcome

Historical origins

Our first question, then, is what are the origins of bioethics? What historical factors have been important in driving concerns about ethical issues in medicine?

The modern discipline of bioethics grew out of traditional medical ethics over the 1960s and 1970s. Appearing first in North America, it has now become a growth industry all over the world.

Applied ethics, of which bioethics is an offshoot, is of course nothing new. In classical Greece, 'How should we live?' and 'What makes a life worth living?', were among the core questions with which philosophers were concerned. Ethical codes, too, have a long history: perhaps the most famous code of all is the medical 'Hippocratic Oath', written, probably by Hippocrates' students, in the fifth century BC. Even patient autonomy, the *summum bonum* of modern bioethics, has its origins, as the German doctor and historian of medicine, Ulrich Tröhler, has shown, in nineteenth and early twentieth century concerns about patient consent (Tröhler, 2002). So, just why did 'bioethics' spread so rapidly around the world in the last quarter of the twentieth century?

EXERCISE 1

Think about this question for yourself before turning to the reading:

- List any factors that you believe may be behind the rapid growth of modern bioethics in the second half of the twentieth century.
- Then note the factors identified in the three extracts from:

  Maehle, A-H. and Geyer-Kordesch, J. (ed.) (2002). Introduction, pages 1–9 in A-H. Maehle and J. Geyer-Kordesch (eds). *Historical and Philosophical Perspectives on Biomedical Ethics: from Paternalism to Autonomy?* Aldershot, England: Ashgate Publishing Limited. (Extracts pps 1–3).

Link with Reading 18.1

Maehle and Geyer-Kordesch are both historians of medicine. This edited collection, although not attempting an exhaustive treatment of the subject, provides many important historical insights into the growth of modern bioethics. History, as we noted in Chapter 7, is not futurology; but the perspectives of history on bioethics can help us to understand its emerging limitations as well as its evident successes.

Five historical factors

In these short extracts from their introduction, Maehle and Geyer-Kordesch (2002) touch on a number of factors widely regarded as being important to the growth of bioethics. There are no doubt other factors: and their list may be different from yours (in the first part of Exercise 1 above). Historically, each of the factors identified by Maehle and Geyer-Kordesch is worthy of a chapter in its own right. But briefly, these include:

1. *Mid-twentieth century atrocities*. The Nuremberg trials, noted in the second extract from Maehle and Geyer-Kordesch (pp. 1–2), shocked the world not just for the gross abuses of human rights they revealed, but for the complicity of doctors in those abuses in the name of medical research.

2. *Rapid advances in medical science and technology*. Maehle and Geyer-Kordesch open their Introduction with this factor. 'New technologies', they say (first extract, p. 1), create new ethical dilemmas'. This has been true in the past as well as today: a little later (p. 2), Maehle and Geyer-Kordesch pair Mary Shelley's nineteenth century cautionary tale of *Frankenstein* in the same paragraph with Dolly the Sheep (Dolly was the first successful sheep clone). From the 1960s onwards we have witnessed medical science and technology advancing at an unprecedented pace. Combined with the loss of trust in medicine arising from a recognition of the abuses to which medical science can be harnessed, technological advance has been a major factor in the growth of corresponding ethical

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concerns. The bottom line of Chapter 17 was that *bio*ethics, or *bio*medical ethics as Maehle and Geyer-Kordesch call it in the introduction to their book, is aptly named as a response predominantly to *bio*medicine.

3. *Opening up the doctor–patient relationship*. In part because of a loss of trust in medicine, the hitherto privileged status of the doctor–patient relationship was challenged by other professionals, notably, as Maehle and Geyer-Kordesch indicate, 'lawyers, moral philosophers, theologians, and sociologists.' Although only touched on by Maehle and Geyer-Kordesch (at this point in their Introduction), the shift from trusting relationship to legal contract in the doctor–patient relationship has been a major factor shaping modern bioethics. The founder of the first modern centre for bioethics in the UK was a lawyer, Ian Kennedy. Kennedy's landmark publication on the subject was called evocatively *The Unmasking of Medicine* (Kennedy, 1981, emphasis added as underline).
4. *Wider social changes: the Civil Rights Movement*. An important factor in the United States was the 1960s rise of civil rights. As Maehle and Geyer-Kordesch put it, the momentum created by the movement for 'equality of ethnic minorities, and women's liberation paved the way for patients' rights and a new approach to ethics in medicine' (p. 3). From North America, then, as the birthplace of 'bioethics', this 'new approach' spread to western Europe and around the world.
5. *The Four Principles*. Maehle and Geyer-Kordesch are perhaps unusual in emphasizing the importance of Tom Beauchamp and James Childress' (1989) book on the *Principles of Biomedical Ethics*.

We return to the four principles (autonomy, beneficence, non-maleficence, and justice) below. We will see that they have been subject to wide-ranging criticisms. As historians, though, Maehle and Geyer-Kordesch are perhaps better placed than many to recognize the significance of this book, first published in 1979, in the development of bioethics. Coming as it did when the new movement was expanding rapidly, it provided a comprehensive framework for tackling ethical problems, philosophically well-grounded (Beauchamp is a philosopher; Childress a theologian), and yet directly practical in application. As such, it gave expression to, and consolidated, what has become perhaps the defining feature of the new bioethics, patient autonomy. Since the publication of this book, Maehle and Geyer-Kordesch say (third extract, p. 3), 'It has . . . become customary to view modern biomedical ethics as being guided by the principle of patient autonomy. The older medical ethics, by contrast, are usually seen as an expression of the beneficent paternalism of doctors.'

From origins to aims

The origins of bioethics, as a modern offshoot of applied ethics, can be summarized thus: bioethics developed in response to medicine's complicity in mid-twentieth century abuses of human rights, which, combined with Frankenstein fears of rapidly advancing medical science and technology, led lawyers and others to open up the previously sacrosanct relationship between doctor and patient, putting patients' rights in place of trust in doctors, and patient autonomy in place of medical patemalism.

The corresponding aims of bioethics can be summarized similarly: bioethics aims to empower patients, giving them autonomy in how they are treated, by codifying their legal rights to self-determination, thus breaking the power of the 'doctor-knows-best' assumption of medical paternalism, and controlling the uses to which advances in medical sciences and technology are put, all with the ultimate aim of ensuring that abuses, such as those witnessed in mid-twentieth century Europe, never happen again.

Bioethical outcomes

But how have things worked out? There is little doubt that doctors are more conscious of the need to get patients' consent to treatment. And as Maehle and Geyer-Kordesch (2002) note, in terms of outputs, the proliferation of ethical codes and legal sanctions is a matter of historical fact.

But, again, how have things worked out? Have these developments led to improvements in health care? It is perhaps little short of heresy in the current climate to suggest that bioethics might be in some respects *bad* for our health! However, we noted in Chapter 17 the relatively 'late and local' nature of bioethics' guiding principle of autonomy: it is a late comer to medical ethics, historically speaking; and it is a local, not universal, principle, being recognized only in those cultures that value individuals ahead of families and the wider community. So what about bioethics as a whole? *Has* it been good for our health?

EXERCISE 2

Think about this question before going on. Concentrate here on bioethics as a whole rather than this or that 'school' or approach. And focus on the way bioethics has actually *worked out in practice* rather than on its nature as an academic discipline.

Write down any 'downsides' of the practical impact of bioethics that you can think of.

As an academic discipline bioethics has developed a rich tradition of scholarship spanning not only history and philosophy but also such disciplines as politics, economics, psychology, and social theory. It has an expanding research base, too, encompassing a range of empirical as well as legal and ethical methodologies (Fulford *et al.*, 2002a).

As a practical discipline, by contrast, bioethics has developed largely as an extension of medical law. We can understand this in terms of its origins and aims: the perceived need was for medical science and technology to be regulated by laws strengthening patients' rights. Bioethics has thus sought to give these laws 'teeth' by detailing their implications in codes and guidelines, supported, where necessary, by quasi-legal regulatory bodies with powers of interpretation and enforcement.

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Three bioethical downsides

It is predominantly by way of quasi-legal 'rules and regulation', then, that bioethics has interacted with practice. This 'quasi-legal' approach has important strengths (see below). Paradoxically, though, it has also had a number of 'downsides' (Fulford, 2001).

Different groups, different individuals, identify different downsides to the growth of quasi-legal bioethics in health care. We will see later that these differences reflect different value perspectives. The downsides identified by a group of senior health-care providers—mainly voluntary and statutory sector chief executives—are given in Table 18.1. Your lists may of course be different. Summing across different groups, though, the downsides to quasi-legal bioethics can be thought of as falling into three broad areas that we will call, code inflation, practitioner deflation, and problem conflation.

1. *Code inflation: the growth of rules and regulation*. Maehle and Geyer-Kordesch (2002), in the reading linked with Exercise 1, touch on the growing tide of codes and other regulatory documents. The British Medical Association, whose guidance on ethics for doctors 50 years ago was a slim-line leaflet, has just published its latest advice in an 800-page *magnum opus*.

   Such code inflation would be acceptable if it were having its intended effects. But as Maehle and Geyer-Kordesch note, at the end of the second extract (pp. 1–2) from their Introduction, in volume and complexity alone, modern ethical codes are becoming counter-productive; and as they signal at the end of the third extract (p. 3), it is far from clear that, even as a way of securing patient autonomy, the rules and regulations approach is proving effective.

2. *Practitioner deflation: defensive (and other bad) practices*. The original mainspring of bioethics, as noted above, was a desire to prevent abusive misuses of medical science and technology: 'never again' was the watchword after Nuremberg. But no set of rules and regulations can ever be foolproof. There is always an 'again'. There is always another 'scandal' when the rules and regulations are breached. So there is always a perceived need to tighten up the rules and regulations still further. A vicious cycle, of which code inflation is the main symptom, is the inevitable result.

   Again, practitioner deflation might be acceptable if it were effective. But the rules and regulations to which health-care practitioners are subject, have become increasingly divorced from the realities of practice, to the extent that far from preventing bad practice they are in some cases actually promoting it. The most direct effect of this has been the growth of 'defensive practice': health-care decisions increasingly being taken, not in the best interests of clients or patients but on the basis of least risk of being hauled up before an ethics tribunal, or, indeed, finding oneself in court (Fulford, 2001).

   Other adverse effects on practitioners noted in Table 18.1 include 'burn out', a culture of mutual suspicion rather than of collaboration, and the squandering of health-care resources on litigation.

3. *Problem conflation: disadvantaging patients*. Less well recognized, perhaps, but certainly the most significant downside of the quasi-legal form in which bioethics has interacted with

Table 18.1 'Downsides' to quasi-legal bioethics identified by one group of senior health-care service providers

◆ Cross-culturally insensitive
◆ Makes doctor–patient relationship impersonal
◆ Leads to hostility
◆ Risk phobic
◆ Rights obsessed
◆ Too many guidelines
◆ Contradictory guidelines
◆ 'Burn out'
◆ Defensive practice
◆ Cost of litigation rising
◆ Conflicts with individual needs/wishes

Fig. 18.1

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practice, has been the extent to which it has had the opposite of its intended effects.

As noted above, and as we will consider in more detail below, rules and regulations have an important place in health care. But the *extent* to which they have been taken has resulted in patients actually being *dis*empowered, rather than, as intended, *em*powered. The British social scientist, Patricia Alderson, was among the first to point out this paradoxical effect of the new 'profession' of bioethics: patients, she pointed out, once disenfranchised by the specialist knowledge of the medical profession, are now doubly disenfranchised by the growing specialist knowledge of the new professional ethicist (Alderson, 1990, 1994). Similar concerns are beginning to be raised about the growing bureaucracy of research ethics committees (Gennery, 2005; Osborn, 1999; Savulescu, 2001; Warlow, 2005). In place of the traditional hegemony of 'doctor knows best', then, as one of us has put it elsewhere, we are at risk of a new hegemony of 'ethicist knows best' (Fulford *et al*., 2002a, p. 4).

There is of course a growing and ever more powerful 'patient voice' in health care, a voice that is increasingly well able to take on the ethical as any other professional mafia! The effects of over-regulation, though, will continue to be felt most acutely by vulnerable groups. In the UK, for example, a Data Protection Act, designed to secure patients' rights to confidentiality, has been perceived by those concerned as so draconian that, defensively, they have sometimes failed to communicate information when this was essential to good clinical care. This has become a generic concern in mental health with its reliance on multidisciplinary and multiagency team working for effective 'care in the community' (Szmukler and Holloway, 2001). It has also had recent tragic consequences in the UK in failures of child protection.

Defenders of the rules and regulations approach of quasi-legal bioethics rightly point out that, in principle, their legislation always includes safeguards: the UK's Data Protection Act provides for sharing of information in certain circumstances, for example. But we need to take seriously the fact that such safeguards, included as (what are perceived as regrettable) exceptions within a legislative framework that is designed to drive practice in an entirely different direction, are proving, at best ineffective, at worst counter-productive.

Again, ethical regulation and a framework of law are essential tools to support health-care practice. It is an *over*-reliance on these tools, treating them as if they were the only tools we need, that results in the downsides outlined in this section. So, what other tools are available from ethics to support health-care practice? As a first step towards answering this question, we will consider the downsides to bioethics, arising from overuse of the quasi-legal tools of rules and regulation, in the light of the work we did on the conceptual structure of health care in Part I.

Codes, concepts, and clinical practice skills

The point of drawing out and focusing on the ethical 'downsides' to bioethics, then, in its predominantly quasi-legal interactions with practice, is not to suggest that we can do without codes of practice, still less a framework of law, altogether. On the contrary, as tools in the toolkit, as we put it above, they are essential. Clear statements of rights, indeed, backed with legal action, have been important in rolling back embedded prejudices. They remain important, as we will see later, in providing a framework for practice. But the point is that if these tools are the *only* tools in the toolkit, and if therefore they are used for the wrong task, or for the right task in the wrong way, they can become counter-productive: like using a hammer to tighten a screw, or a screwdriver to hammer in a nail!

So, what has gone wrong? The historical origins of bioethics, in gross abuses of human rights, explains its over-reliance on quasi-legal tools. But what, exactly, is the *right* use of such tools? Why, exactly, are they no *panacea*? And what *other* tools do we need?

EXERCISE 3

Think about these three questions. There are a number of ways they might be approached—through jurisprudence, for example, or political theory.

But think about them with the work we have done in earlier parts of this book in mind. In particular,

1. Part I generally, on concepts: What kind of answer might Austin have given to these questions in terms of his key methodological distinction between definition and use?
2. Part III, in particular the second half of Chapter 14, on implicit (or craft) knowledge: are the decisions that quasi-legal ethics seeks to control simple or complex? If complex, what does this imply about the ways in which they might be guided?

Code inflation: definition and use

Austin's ideas, in Part I, about philosophical fieldwork, started from a recognition of the limitations of explicit definitions: remember St Augustine's complaint that he knew what he meant by time until somebody asked him!

Lawyers, like doctors, believe in starting by defining their terms. As we saw in Part I, this can be helpful. But there are also situations in which language use is more helpful than definition as a guide to meaning. Hence one way to understand the downsides to over-reliance on the tools of quasi-legal bioethics, is that they could be a result of an over-reliance on explicit definition. 'Code inflation', in particular, as we called the first downside to quasi-legal ethics, could arise when we try to define the indefinable. Attempts to anticipate and to close down all 'loopholes' could fail essentially because the key concepts expressed in our codes are higher-level concepts, concepts of the kind, like time, that we are better able to use than to define. We explore this possibility further in the next reading.

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EXERCISE 4

Read the following version of the Hippocratic Oath from:

Dorland's American Illustrated Medical Dictionary, (25th edn). (1974). Philadelphia, PA: Saunders.

Link with Reading 18.2

- List the main prescriptions of the Oath.
- What 'higher-level' concepts can you identify?
- How does the Oath avoid the limitations of explicit definition?

As the most famous of medical codes, the Hippocratic Oath avoids the problem of defining the indefinable by taking the form of an overall framework of general principles reflecting higher-level concepts, and, rather than seeking to define these sufficiently to cover all contingencies, it provides a number of concrete specific examples.

A framework of general principles

The power of this approach is reflected in the fact that many of the 'framework principles' in the Hippocratic Oath sound surprisingly modern! Thus the principles of beneficence and non-maleficence are directly reflected in the Hippocratic injunction that 'I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone.' The opening clauses of the Oath, about professional solidarity and peer education, are perhaps less significant nowadays—but many perceive a clear need to move them back up the agenda! Confidentiality, much in the news at present, is mentioned towards the end. There is a familiar injunction against seducing one's patients or members of their households. There is also a clear reference to working within one's area of professional expertise (not to 'cut for stone'). True, there is no mention of 'autonomy'. But autonomy, as we have several times noted, is a 'late and local' value in health care.

Some of the many higher-level concepts shaping these principles are evident enough: 'beneficence' and 'non-malevolence', noted above, are higher-level ethical concepts. Other such concepts are less evident but no less important to the structure of the Oath. Thus, in the opening clauses the very scope of application of the Oath is defined by a brief reference to 'this art'. Well, what art? The Oath is assumed to be a *medical* oath; and Hippocrates was a physician; but there is no attempt directly to define the 'art' in respect of which the Oath is taken. And wisely so, perhaps, given that any definition of 'medicine' would turn (in part) on definitions of such contested concepts as 'illness' and 'disease'.

'Confidentiality' may seem more straightforward, but it turns out to be highly complex conceptually (Fulford, 2001). Correspondingly, therefore, the Hippocratic Oath neatly sidesteps any difficulties of definition with a tautology: physicians, the Oath enjoins, are to keep confidential only that 'which ought not to be spread abroad.'

Same principles, different examples

The Hippocratic Oath, then, specifies, but does not seek to define, its own key concepts. It does, however, moving in Austin's terms from definition to use, illustrate its key concepts with specific examples. And whereas the general principles often seem familiar by modern standards, some of the examples, by contrast, seem distinctly odd.

Avoiding harm, for instance, for most doctors, certainly does not extend to refusing abortion; and even the prohibition against administering a deadly poison is being actively challenged by a growing pro-euthanasia lobby. Similarly with professional solidarity, few if any of the health-care professions would recognize this as extending to living 'in common' with one's teachers, still less to sharing one's worldly goods with them; and neither teacher nor pupil, nowadays, would welcome the relationship of parent and child! 'Cutting for stone', again, *is* now a properly *medical* activity, surgeons being part of the profession. The ban on 'pleasures of love', although still applicable to one's patients, does not extend to their family members, servants, and friends (providing always that these fall outside one's professional relationships). And keeping secret the 'precepts and instruction' of medicine would be considered positively *un*ethical nowadays: the emphasis today is all on openness and sharing of medical information.

The currency of the Hippocratic Oath is thus to be found primarily in its general principles rather than in the specifics of how these principles are applied. But the specifics, we have suggested, are, in Austin's terms, the higher-level concepts in *use*. And use, we learned in Part I, is a better guide to meaning than explicit definition. So the variations between Hippocrates' time and our own in the specifics of the Oath reflect variations in values that are *considerably wider* than is apparent from the shared higher-level concepts—solidarity, beneficence, etc.—in terms of which the Oath's general principles are defined. We share the same 'framework' principles, certainly, principles such as beneficence and solidarity. But those same principles, if the examples given by Hippocrates are any guide, meant something very different when the Oath was written from what they mean today.

Codes as a framework of shared values

This J.L. Austin-led interpretation of the Hippocratic Oath suggests that one proper role for codes, as a tool in the ethical toolkit, is to give expression to those values that are shared within a given group. That the particular meaning attached to these 'framework values' as we might call them, changes, from time to time, from culture to culture, from person to person, and so on, may seem, to the moral absolutist, to undermine the cogency of such values. But understood as higher-level concepts, such variations are no more than we should expect: to revert to our example in Part I, interpretations of the meaning of 'time' vary while time remains none the less an essential higher-level concept for physics.

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As to practical utility, we noted above the effectiveness of 'codes' in highlighting and pushing back against abuses. A currently important example, highlighted by the Hippocratic Oath, is the value of professional solidarity. Currently lost in the glare of the new value of patient autonomy, the value of professional solidarity is perhaps overdue for a come back. One factor in the current demoralization of health-care professionals is their loss, severally and together, of professional collegiality. We need to rethink what professional solidarity means in the twenty-first century. We should not wish to return to the medical cartel. But the Hippocratic Oath, in prompting such a rethink, would be prompting us to think precisely what the value of professional solidarity means for our particular time, for our particular place, for our particular culture. The results of such a rethink would be specific examples, different from those of cohabiting and sharing of goods in the original Hippocratic code, but relevant to professional practice today.

A proper use of codes, then, in answer to our first question above, is to give expression to the framework values shared by a given group. Such frameworks, to the extent that they rely on higher-level concepts, should be cast in general terms rather than attempting to define specific rules to cover all contingencies. If further guidance is needed, then specific examples, rather than more detailed rules and further regulation, are appropriate.

A paradigm of this approach, balancing general principles and specific examples, is the Code of Practice of the Royal Australian and New Zealand College of Psychiatrists (1998): this gives general principles applicable across the college as a whole with annotations specific to each subspecialty.

Codes are no panacea

This J.L. Austin led interpretation also gives one kind of answer to the second of our three questions immediately preceding Exercise 3 above, namely, why, exactly, codes, although in some respects practically effective, are no panacea. Thus, the specific meanings attached to shared values, we have suggested, vary not only across historical periods but also from culture to culture, and even from individual to individual. Hence, the more energetically a code seeks not only to express shared values but also to pin down the specific meanings to be attached to those shared values, the greater will be the opportunities for conflict between the values expressed by the code and the values of those to whom the code is intended to apply. Pinning the specifics down in one way may be consistent with the values of *some* individuals within the group; but given the variation in human values, it will be inconsistent with the values of *others*.

Code inflation, then, arises from the (understandable) attempt to close loop-holes by writing ever-more detailed rules to cover all contingencies. Codes, though, if the Hippocratic Oath is any guide, rely on higher-level concepts, that, we found in Part I, are beyond the reach of complete definition. Code inflation, in consequence, is (1) mistaken in principle, in that it involves, as we put it above, defining the indefinable, and (2) unhelpful in practice to the extent that, in moving beyond general statements of the shared framework values with which codes are properly concerned to detailed rules of application, they will necessarily be in conflict with the values of many of those to whom the codes in question are intended to apply.

Professional deflation: explicit and implicit knowledge

Code inflation, and the conflicts of values to which this gives rise, is itself one reason for 'professional deflation', the second of the downsides to overuse of quasi-legal ethics noted above. Confidentiality in mental health, as we noted above, provides a current case in point. Quasi-legal ethical, and indeed legal rules, in seeking to pin down confidentiality of patient information, have squeezed professional practice to the point that the sharing on information on which good practice in mental health depends, is at risk of increasingly being squeezed out. Professionals are thus left in a 'damned if you do, damned if you don't' double bind, a recipe for defensive practice, demoralization and burnout if ever there was one.

A second reason for professional deflation is to be found in the nature of the decisions by which professional practice itself is characterized. We will look at this briefly in the next exercise.

EXERCISE 5

In the above example, we used the conflict between the values of confidentiality and sharing of information. Both values, at least in mental health, are important. They are, then, in the sense outlined above, shared framework values. Yet they are in conflict.

Now go back to the Hippocratic Oath. What has it to say about this?

As you reread the Hippocratic Oath, think particularly about the nature of the kind of knowledge on which you would draw in balancing confidentiality and sharing of information in the concrete circumstances of a particular case. In the terms of Part III (Chapter 14) of this book, is this explicit or implicit knowledge? If the latter, what does this say about the overuse of quasi-legal ethics and 'professional deflation'?

As noted above, confidentiality is one of the higher-level shared values expressed by the Hippocratic Oath. It is worth looking at the relevant passage in detail, though. In the first place, it differs from modern codes in calling for confidentiality of 'All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men . . .'. So it is a good deal broader than, merely, professional ethics. But this otherwise impossibly high standard is then, in the next passage, sharply restricted to such knowledge as 'ought not to be spread abroad'.

A tautological principle, then, as we noted above! And unlike other principles in the Oath, we are given no specifics. So we have no direct guidance on precisely what information, at Hippocrates' time, 'ought not to be spread abroad'. We can make

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educated guesses, though, by taking this principle along with others. The principle of professional solidarity would preclude spreading abroad the 'precepts and instruction' of the art, at any rate beyond the family of the physician's teacher and properly signed up pupils. As noted above, this directly conflicts with modern views on what counts as 'sensitive' information.

Suppose, on the other hand, it comes to your attention, as a physician in Hippocrates' time, that someone from a different 'college' is planning, in the words of the Oath, to 'give a woman a pessary to secure an abortion': presumably that *should* be spread abroad. But what if the person giving the pessary is a colleague? How does professional solidarity square with the prohibition on abortion when it comes to confidentiality? Or what if the woman is your sister and is pregnant through rape? Ought your knowledge that a colleague is about to give her a pessary to secure an abortion, be spread abroad; or would the resulting harm, to both your colleague and sister, outweigh the demands of the anti-abortion principle? Note here that the injunction against doing harm is general, it is 'never do harm to *anyone*', not just to patients through the exercise of the art.

Balancing framework values

The problems of balancing confidentiality, as one framework value in the Hippocratic Oath, against others, are thus evident enough. Similar problems are familiar enough in present-day discussions of ethical issues. However ready we are to sign up to any one of the values expressed by a code, there will always be difficulties arising from trading one value against another in the concrete particulars of everyday practical situations. 'Particularism', as it is sometimes called, the extent to which moral judgements are particular or can be subsumed under general rules, has been widely discussed in ethical theory (see, e.g. Hooker and Little, 2000). In relation to codes, though, and the 'professional deflation' downside of the overuse of quasi-legal ethics, it is helpfully understood in terms of a distinction more familiar in the philosophy of science, between explicit and implicit, or craft, knowledge.

Thus, the trade-offs required in practice between the different values expressed in a given code, suggest that the decisions required of professionals are necessarily highly complex. Even, therefore, granted excessive zeal on the part of code makers, there will be barriers of principle to full codification of the rules for successful trade-offs. In other words, rather like riding a bicycle, no set of explicit rules will ever be sufficient for successful performance of the required trade-offs between values. Such trade-offs, to the contrary, will rely on implicit knowledge, knowledge of the kind that professionals, after training, characteristically display; knowledge that is acquired through experience rather than from 'book learning'; knowledge that is aptly called 'craft' knowledge. (Hence the reference in the above Exercise 5 to implicit knowledge in Part III, chapter 14.)

Professional judgement

It may be no coincidence, then, that in the Hippocratic Oath, the physician is required to practise his art 'according to my ability *and my judgement*' (emphasis added). Certainly, the distinction between explicit knowledge and craft skills was well understood in Classical Greece: the distinction, you will recall from Part III, was made explicitly about a hundred years after Hippocrates, by Aristotle, who distinguished logic and other forms of discursive reasoning, from what he called in *The Nicomachean Ethics* ('Ethics') (2000), 'practical reasoning'. At all events, the implications for practice are clear. Attempts to apply ethical codes, not for their proper purpose of giving expression to the high-level values shared within a profession, but for the purpose of specifying in detail how these values are to be balanced in particular circumstances, will end up, as it were, cutting the craft from under the feet of the professionals concerned. Small wonder, then, that when codes are used to pin professionals down ever more tightly in their day-to-day practice, they are demoralizing in their effects. They are, literally, de-professionalizing.

There is a middle path to be struck here, of cause. *Some* guidance is required, indeed helpful, if only because professions progress and new kinds of decision are constantly arising. But writing ever more detailed codes is not the answer. And there *are* alternatives. One alternative, the most directly indicated by the 'craft knowledge' model of values trade-offs, is wider use of case examples, as in the Hippocratic Oath itself. Such examples tap directly into the well of implicit knowledge and they translate readily into practice. Law, indeed, where it relies on cases, works well in this respect. There are new questions here, arising from the changing role of patients, about *whose* experience should guide decision-making. Balanced decisions can no longer rely on the experience, merely, of the professional. We must find ways of incorporating also the experiences of patients (Fulford, 2001). All the same, implicit as well as explicit knowledge, is irreducible if the trade-offs required between the different values expressed by codes are to be successfully negotiated in the values-complex environment of everyday practice.

From right outcomes to good process

As tools in the ethical toolkit, codes of practice, and the regulatory bodies responsible for interpreting and enforcing them, are outcome focused: they prescribe 'right outcomes' by which clinical (and managerial) decisions should be guided.

This is the strength of quasi-legal bioethics. Like a rights-based legal framework, prescribed right outcomes set clear limits, defined, as we have seen, by shared values. It is also its focus on 'right outcomes', however, that leads to some of the downsides of quasi-legal bioethics if it is the only tool in the toolkit. It is *over*-specification of outcomes that leads to the vicious cycle of code inflation. It is *over*-regulation of the trade-offs between rules, leaving insufficient space for professional discretion reflecting implicit knowledge gained through experience, that leads to professional deflation.

This brings us to the third question raised at the start of this section, namely, what further tools are needed for the ethical toolkit. For if the tools of quasi-legal ethics focus on outcomes,

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and if it is this focus that makes them counterproductive if overused, then there is a clear case for a switch from outcomes to process—not, of course, to throw out the tools of right outcomes, but to add to them tools of good process.

Advocates and adversarial 'good process'

One tool of good process, of which excellent use has been made in law, is advocacy. Due process in many court proceedings is secured by both sides appointing advocates who then argue their respective corners in front of an impartial judge, and, in serious cases, a jury. The outcome of this process, within wide limits, is not pre-judged but depends on the case advanced by each side operating within a broad set of rules of procedure designed to ensure fair play. Such rules, it is important to emphasize, are essential. But they are aimed at securing good process rather than this or that particular prescribed 'right' outcome.

Problem conflation: adversarial and other 'tools'

Advocacy, as a tool of good process, has an important place in health-care ethics when we come to the third downside of the overuse of quasi-legal bioethics, problem conflation. Problem conflation, you will recall, was the paradoxical result that rules and regulations, designed to secure the rights of vulnerable groups, if taken to an extreme can have the opposite effect. They can put at risk just those vulnerable groups they were designed to protect.

Problem conflation is a clear consequence of the outcomes focus of quasi-legal ethics. The values of vulnerable groups are as diverse as those of any other group. If outcomes are *over* specified, therefore, the necessary conflicts of values noted above, between the outcomes specified and the values of those falling under the rules and regulations in question, will arise for vulnerable as for any other groups. Vulnerable groups, though, by definition, will be less able to fight their corner than non-vulnerable groups. Vulnerable groups, therefore, more than non-vulnerable, are at risk of what we called earlier, 'ethicist knows best'.

Advocacy, as a tool of good process, can be helpful, therefore, in securing a balanced approach to clinical decision-making. The difficulty, though, with advocacy is that it so readily becomes adversarial, a contest in which those with the resources to pay the most effective advocates come out top of the league. Advocacy alone, therefore, although a further useful tool in the toolkit, will never be sufficient to avoid problem conflation. So long as we rely on an essentially adversarial process for resolving questions of value, whoever is at the time disadvantaged, inherently or through lack of support, will lose out.

Three tools of bioethical reasoning

The tool of adversarial exchange, then, like outcome-based codes, is important in its place but not sufficient (in itself) to support good process in clinical decision-making where, as in health care, 'good' is measured from the perspective of vulnerable groups. So, what other tools are available? In the final section of this session we introduce three such tools derived from modern bioethics—principles, casuistry, and perspectives. As we will see, these are three methods of ethical reasoning, or reasoning about values, that, in the values-complex environment of modern health-care decision-making, are rapidly becoming recognized as essential clinical practice skills. We consider the strengths and weaknesses of these three tools specifically for mental health ethics in Session 2 of this chapter.

Principles, causitry, and perspectives

There are two main approaches to practical ethical reasoning in the bioethical literature, *principles* and *causitry*. To these, the psychiatrists and Professor of Medical Ethics in Oxford, Tony Hope, has added a third approach, *perspectives* (Hope *et al.*, 1996). In this section we will first outline each of these approaches and then consider their strengths and weaknessess generally in health care. As just noted, we turn to their applications to mental health in Session 2.

The four principles

As indicated above, the principles approach was developed originally in America at Georgetown University by Tom Beauchamp and James Childress in their *Principles of Biomedical Ethics* (1989). In the UK the approach has been taken up and extended by the first Professor of Medical Ethics at Imperial College in London, Raanon Gillon. His *Philosophical Medical Ethics* (1985, and subsequent reprints) helped to introduce bioethics into British medicine and remains a valuable introduction to the subject. In his monumental *Principles of Health-care Ethics* (Gillon and Lloyd, 1994), original articles were gathered together on every aspect of bioethics exploring the strengths and weaknesses of the four principles approach.

Gillon, although openly an enthusiast for the four principles as a framework for ethical reasoning, has been careful to spell out the limitations of the approach: they can provide a common moral framework, but within this framework people may none the less disagree (they may 'weigh' the principles differently, for example). Moreover, there are important issues raised by the *scope of application* of the principles (Gillon, 1994). The scope of the principles was largely taken for granted in Beauchamp and Childress' (1989) original book but it becomes important when we move from the clear-cut dilemmas of technological medicine to the more heterogeneous difficulties raised by primary care. As well as being a leading medical ethicist, and at the time of writing his 1994 article, editor of *The Journal of Medical Ethics*, Gillon was indeed a primary care physician (working as a family doctor).

Turning to the four principles themselves, then, they are:

1. *Autonomy*: respecting the patient's wishes
2. *Beneficence*: doing good
3. *Non-maleficence*: avoiding harm
4. *Justice*: in particular, fairness in the provision of care

These are prima facie principles (Beauchamp and Childress' term). That is, they are all prima facie relevant to ethical issues in

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health care and have to be balanced one against another in particular cases. There are no general rules for balancing principles. This has to follow intuition.

It is often said against the principles approach that it is too algorithmic—you feed in the problem, crank through the principles, and get out an answer. Gillon makes it clear that such mechanical uses of the principles approach would be quite wrong; and in their book, Beauchamp and Childress (1989) themselves carefully spell out that this would be a gross misuse of principles reasoning.

Casuistry or case-based reasoning

The principles approach is top down. It tackles ethical problems by applying general principles to particular cases. The casuistic approach is bottom-up. It starts from particular cases. Where there is a dilemma or disagreement, casuistry asks two questions,

1. what *changes* to the case can you imagine that would make it clearer what to do, and
2. what *related* cases would be either more or less problematic ethically.

Historically, casuistry has had a bad reputation. It became associated with the practice of moulding cases to fit ones own beliefs and wishes. The term was rehabilitated recently by two American scholars, Stephen Toulmin (you will recall his article 'How Medicine Saved the Life of Ethics' in the last session), and A.R. Jonsen, in their seminal book, *The Abuse of Casuistry* (1988). In this they describe their experience on an American government committee, the President's Commission on Bioethics. They noted that on many ethical issues, most people on the Commission agreed what ought to be done, but they disagreed about why. This, they argued, showed the irrelevance of theory. The way to reason about ethical issues is not to apply general theories but to look carefully at the details of particular cases.

A valuable introduction to casuistry is the article, 'Medical ethics, moral philosophy and moral tradition', by the American philosopher Tom Murray (1994). Tom Murray, at the time Director of the Center for Biomedical Ethics at Case Western Reserve University, Cleveland, Ohio, went on to become Director of the Hastings Centre and President of the Society for Health and Human Values. In this article he contrasts casuistry with principles reasoning (he calls this deductivism, i.e. deducing moral conclusions from general principles), and sets it in the context of recent work on moral tradition.

Casuistry has sometimes been viewed by ethicists as a competitor to the four principles, even as a more 'advanced' ethical method. There is something of this in Murray's article. He distinguishes two sense of casuistry (though noting that it has many meanings):

1. immersion in the particulars of a case, and
2. the claim that moral judgement rooted in moral tradition (as against philosophical and other moral 'theories') may be a source of moral knowledge, or at any rate guidance.

In the detail and complexity of real life cases, Murray argues, immersion in and interpretation of moral theory are inescapably linked. In real life, moreover, the moral traditions of a culture are an essential resource of moral guidance. In both the above senses, then, ethical reasoning in health care must look to case-based, bottom-up approaches, rather than principle-led, top-down approaches. But is this a recipe for rigid conservatism, for the perpetuation of received values? No, Murray argues, for cultures have a power of dynamic change.

We will return to the importance of the dangers of rigid conservatism in mental health in Session 2. In this respect (and in others), as we will see, the two approaches—casuistry and principles—are complementary in mental health ethics.

Perspectives

The perspectives approach emphasizes the importance in ethical reasoning of the different points of view (ie perspectives) of those concerned (Hope *et al*., 1996). Perspectives are important to both principles and casuistry. How, for example, can the principle of beneficence be applied if we do not understand what someone wants? How, on the other hand, in reasoning casuistically, can the circumstances of a case be varied in an ethically meaningful way without understanding what is relevant from a particular person's point of view?

Perspectives is a relative newcomer on the bioethical scene, essentially because it was always assumed that what people want is more or less transparent. In some cases this may be true—for example, with abortion, or transplant surgery, many of the ethical issues arise from clear *conflicts* of perspectives. However, perspectives may be misunderstood: for example, contrary to the usual expectations of hospital staff, clinical experience suggests that the relatives of young people killed in accidents may sometimes welcome the idea of organ transplantation as a way of allowing something good to come out of something bad.

Misunderstandings about perspectives are especially common in primary care and mental health. This is because, as we saw earlier, people's values are inherently more diverse in this area.

Perspectives are particularly well brought out through the literary and other resources of what are often called narrative ethics. An early case study in narrative ethics that draws out the perspectives of all those involved in a vivid and highly readable way is by Alastair Campbell (a philosopher) and Roger Higgs (a family doctor) (1982), in their book 'In that care'.

Strengths and weaknesses

In practice, especially in mental health, these three approaches—principles, casuistry, and perspectives—are often usefully combined. However, in order to get clearer about the approaches themselves, and to think about their strengths and weaknesses, we will now try using them separately in

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connection with the cases that we considered at the start of Chapter 17.

EXERCISE 6 (30 minutes)

Go back to your initial cases in Chapter 17 and think about how you might use the above three approaches, principles, casuistry, and perspectives, to help resolve the dilemmas or disagreements they raise.

If you are working in a group, a good approach is to agree on a case that you would like to examine in detail (one involving consent always works well); then divide up into three subgroups, each examining the case using one of the above approaches to ethical reasoning.

As you do this, write down your reasoning, noting any advantages/disadvantages of the method that you are working with, and thinking particularly about the four intermediate objectives of training in ethical reasoning we examined in Chapter 17.

Some advantages and disadvantages of the three approaches are listed in Table 18.2. You may have found some extra advantages or disadvantages; and you may agree or disagree with some of those we have listed. But some important general points that often come up include the following:

- The *principles approach* is intuitively straightforward. It has also been shown to reflect many of the ideas that people fall back on naturally when faced with ethical issues in health care: this was shown clearly, for example, by the (at the time) medical student, David Roberston's (1996), empirical and conceptual study of ethical decision making in old age psychiatry.

  The principles approach can be especially helpful in broadening our understanding of a case. In terms of our four intermediate objectives, principles reasoning may: (1) increase awareness (by forcing us to think about more than one aspect of a case); (2) change attitudes (by showing that a particular approach may be biased towards, say, beneficence at the expense of patient autonomy); (3) point to knowledge that may be lacking (this ties in with perspectives especially); and (4) it can improve thinking skills (by giving us a well-structured way of analysing the pros and cons in a given case).

  The main danger with the principles approach is that it can suggest that ethical issues may be solved, like mathematical or scientific problems, in a clear-cut way. In fact, as we noted above, this would be to misunderstand the approach (remember that prima facie principles have to be weighed intuitively); but it is a danger, none the less, especially when the principles approach is used on its own.

- *Casuistry* was developed in part as a response to the misuse of 'principlism'. Based as it is on cases, it has the great advantage of being directly relevant practically. Reasoning about cases is something that all practitioners are familiar with in other clinical contexts, and this kind of reasoning can often lead to agreement.

  One problem with casuistry is that it can be very unstructured. A more significant difficulty, however, especially with the importance of different value perspectives in mental health, is the danger of reinforcing prejudices. Casuistic reasoning only 'goes through' to agreement where the value perspectives of those concerned are in fact shared. But in the case of mental health, as has repeatedly been noted in earlier sections, values are often *not* shared.

- *Perspectives* is the most patient-centred of the three approaches. It is especially important as the basis of good communication, an essential requirement for good practice in health care (Hope *et al*., 1996).

  There are no significant disadvantages to being sensitive to people's perspectives (to their values and beliefs). But unlike principles and casuistry, the perspectives approach, in itself, gives us no method of *reasoning* ethically. Simply being aware of people's perspectives, crucially important as it is, gives us no way of deciding what ought to be done. The perspectives approach provides essential *data* for ethical and other aspects of clinical decision-making; but it has to be linked up to a substantive theory of *some* kind if it is to give grounds for action.

  A related theoretical danger with the perspectives approach is relativism, an underlying assumption that 'anything goes' But it is of the essence of the professional relationship that, as against simple consumerism, there has to be a *balance* of values. (We return to the need for a balance of perspectives below, in Session 4, on Values-Based Practice. See also, Fulford, 1995.). So perspectives are essential (especially in mental health, because of the variety of people's values in this area) but they are not sufficient.

Table 18.2 Advantages and disadvantages of three main approaches to ethical reasoning in bioethics

Main approaches	Advantages	Disadvantages
Principles	Increases awareness Changes attitudes Points to relevant facts Improves thinking skills	Algorithmic approach Professional-centred
Casuistry	Based on real life links with case method Often leads to agreement in practice	Agreement can mean bias, prejudice, and hence abuse Professional-centred
Perspectives	Patient-centred Knowledge-based	No reasoning method Relativism

Each of the three main methods of bioethical reasoning thus offers strengths and weaknesses. In the next session we consider the roles of these methods specifically in relation to mental health.

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Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. By what developments in medicine was the modern emergence of 'bioethics' prompted?
2. Have there been 'downsides' to bioethics? We listed three; what are they?
3. How are these 'downsides' related to the conceptual difficulties of mental health?
4. What three methods of ethical reasoning may be particularly helpful in practice?
5. Are these mutually exclusive or complementary?

Session 2 Bioethics and mental health

In this session, we consider how the three main bioethical approaches to reasoning about values—principles, casuistry, and perspectives—work out in mental health.

We will be considering this question, not in a general way but by reference to involuntary treatment and our responses to the case vignette questionnaire introduced in Chapter 17. You will recall that the Mental Health Act failed to map on to, or fit, our intuitive responses to these cases. The notion of 'psychotic disorder', by contrast, as a particular interpretation of 'serious mental disorder' gave a good fit. But it left open the question of how psychotic disorder itself was to be understood. As such, therefore, it took us little further towards a clearer understanding of the issues involved in those cases (1 and 3) in which, even in the relatively artificial circumstances of a case vignette questionnaire, opinion was deeply split over whether involuntary treatment was justified.

We now take this story a step further with the tools of modern bioethics. As we will see, these provide further clarification but still fail on the central point for mental health ethics of explaining the ethically relevant features of 'psychotic disorder'. We will start with the four principles.

Four principles (top-down reasoning)

An important strength of the principles approach is that it provides an open framework within which to explore the ethical aspects of treatment decisions. It thus looks promising as a way of explicating involuntary psychiatric treatment. It is important to think about this for yourself before taking up the next reading. Hence the next exercise is in two stages.

EXERCISE 7 (60 minutes)

This exercise is in two stages:

Stage 1

Think for yourself about how you would analyse involuntary psychiatric treatment in terms of Beauchamp and Childress' four principles. Try applying the four principles to each of the cases in the case vignette questionnaire from Chapter 17. How well do they 'fit'?

Stage 2

Now read the extract from:

Fulford, K.W.M. and Hope, R.A. (1994). Psychiatric ethics: a bioethical ugly duckling? Chapter 58 In *Principles of Healthcare ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons, (Extract pp. 684–686.)

Link with Reading 18.3

This reading summarizes Beauchamp and Childress' (1989, chapter 3) detailed and carefully worked out analysis of the ethical issues raised by involuntary treatment as these arise in medicine generally, though with psychiatry being taken as a case in point.

As you read through this, think particularly about:

1. how Beauchamp and Childress analyse involuntary treatment in terms of their four principles,
2. the model of autonomy and voluntariness they describe as lying behind and underpinning the application of the four principles to involuntary treatment, and, finally,
3. whether or to what extent their model is consistent with the intuitive responses we made to the case vignette questionnaire in Chapter 17.

That Beauchamp and Childress should in effect take involuntary *psychiatric* treatment to be a subcase of involuntary *medical* treatment is a clear illustration of the point made earlier (in chapter 17), that much of traditional medical ethics reflects an essentially medical model of the conceptual structure of health care. We will see the importance of this in a moment. However, the case example they discuss (Beauchamp and Childress, 1989, p. 80), consistently with the prominence they give to psychiatric cases in their appendix (also in chaptr 17), is about a patient with *dementia*. This underscores the point that Beauchamp and Childress, unlike many in traditional bioethics, take fully seriously the particular difficulties of psychiatric ethics.

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Balancing autonomy and beneficence

Essentially, then, Beauchamp and Childress (1989) take the key ethical issue in involuntary treatment to involve balancing (primarily) two principles: the principle of autonomy (respecting the patient's wishes) and the principle of beneficence (the professional's responsibility to act in the patient's best interests).

Normally, the best guide to anyone's best interests is their express wishes. In the past, however, in a 'doctor knows best' model, professionals have been assumed to be experts to *patients*' best interests. More recently, this 'paternalistic' approach has given way to a recognition of the importance of patient autonomy. But most people recognize cases, even so, where a person's express wishes are not the most reliable guide to their best interests (young children, for example). Hence we cannot simply substitute a 'patient knows best' principle for the old 'doctor knows best' approach. There will always be cases where 'best interests' and 'express wishes' are in conflict, and it is this conflict, interpreted by Beauchamp and Childress in terms of beneficence and autonomy, which is at the heart of the ethical dilemmas and difficulties presented by involuntary treatment.

This then leads naturally into an account of involuntary psychiatric treatment. For mental illness, as we noted in Session 3 of Chapter 17, to the extent that it involves people becoming irrational, impairs their capacity for *rational*, and hence fully *autonomous*, choice. Hence, this is one of the situations in which beneficence may be in conflict with autonomy. Of course, not *all* irrationality impairs autonomous choice sufficiently, or in the relevant way, to justify involuntary treatment. After all, we are all irrational at times! In Chapter 17, we noted that in the case of mental illness at least, it is psychotic irrationality that is (intuitively) required to justify involuntary treatment, but that this begged the question of precisely why. Beauchamp and Childress, correspondingly, turn to philosophical literature on the nature of rationality to draw out the criteria that must be satisfied if a choice is to be considered genuinely autonomous.

The criteria derived by Beauchamp and Childress can be summarized thus. For a choice to be autonomous, it must be: (1) intentional; (2) made with understanding; (3) free from external controlling influence (i.e. uncoerced); and (4) a product of intact cognitive capacities, in particular the capacities for coherent thought and deliberation. Correspondingly therefore, if these criteria are *not* satisfied, a person's choices may not be fully autonomous and involuntary psychiatric treatment may be justified on grounds of beneficence (and/or non-maleficence).

Balancing autonomy and beneficence in mental health

But, and this is a crucial 'but', do these criteria really fit what actually happens? In Exercise 7 (see part 3 of the second stage) you should have tried this for yourself. Beauchamp and Childress' (1989) case example of dementia fits the criteria rather well. But in our case vignette questionnaire, what about the young man with schizophrenia (case 9), say?

You may want to go through the cases again, checking them against the Beauchamp and Childress' criteria, before going on.

But the conclusion that Fulford and Hope (1994) reach is that, sophisticated as Beauchamp and Childress' approach is, and successful as it is in explaining *some* cases of involuntary treatment (including their own example of dementia), it fails to explain a large number of other cases of involuntary psychiatric treatment as they arise in everyday practice in mental health.

A further failure of fit

One indication of the failure of Beauchamp and Childress' (1989) account to explain many cases of involuntary psychiatric treatment, is a failure of fit, as described by Fulford and Hope (1994), between the principles approach and most people's responses to the case vignette questionnaire we introduced in Chapter 17. This 'failure of fit', between our responses to the questionnaire and the Beauchamp and Childress criteria, is illustrated in Table 18.3 (which is based on figure 58.2, p. 687 in Fulford and Hope, 1994). You may well disagree with some of the details, but the overall conclusion is clear, that the criteria proposed by Beauchamp and Childress, like the legal criteria in chapter 17, simply fail to fit our intuitive responses to most of these cases.

Three points are important to emphasize before going on:

1. This further 'failure of fit' does not, in itself, either validate or invalidate our intuitive responses. This goes back to a point made in Chapter 4, in the discussion of the implications of philosophical work on the concepts of mental illness: a good philosophical theory of mental illness must explain the features of the logical geography of the concept, either why it *has* the features it has, or why it only *appears* to have these features. In Chapter 4, it was the overall 'map' of psychiatry we had in mind; here, it is the pattern of involuntary psychiatric treatment. The Beauchamp and Childress criteria fail to account for this pattern either as reflecting *justified* involuntary treatment or as reflecting involuntary treatment that only *appears* to be justified.
2. The failure of fit does not, in itself, show that the principles approach, as such, is wrong. The underlying analysis of rationality is, perhaps, wrong (at least in part). But involuntary treatment is, none the less, appropriately analysed, among other ways, in terms of a balancing act between beneficence and autonomy.
3. Neither does the failure of fit, in itself, show that the underlying analysis of rationality is, as such, wrong. On the contrary, the analysis really *does* fit many cases of involuntary treatment, in general medicine, and even in psychiatry. It fits some cases very well, notably Beauchamp and Childress' own case of dementia. The point is that the analysis fails to fit the *full range* of diverse cases represented by involuntary *psychiatric* treatment. This is the full-field/half-field point again, then, to revert to the summary diagram at the end of Chapter 6. Beauchamp and Childress offer us a half-field view, sufficient for most areas of bodily medicine, but not the full-field view that is required for a satisfactory analysis of the conceptual and ethical issues raised by mental health.

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Table 18.3 Correlation between results of the case-vignette study (column 2) and the principles of beneficence and autonomy (Adapted from: Fulford, K.W.M. and Hope, T. (1994). Psychiatric ethics: a bioethical ugly duckling? In *Principles of Health Care Ethics* (ed. R. Gillon and A. Lloyd). Chichester: John Wiley and Sons, pp. 681–695) (cases re-ordered in descending order of likelihood of involuntary treatment.)

	Likelihood of involuntary treatment (%) in case study	Beneficience	Autonomy					Psychotic symptoms
			Not intentional	Lacks understanding	Controlling influences	Competence		
						Lacks deliberative capacity	Incoherence	
4 hypomania	100			+		+	+	++
9 schizophrenia	100						+	++
3 depression	50	+						+
1 anorexia	25	+						?
2 obsessional disorder	10							
7 hysteria	<5		?	+				
5 optic atrophy	<5		+	+				
12 marital problems	<5							
13 personality disorder (drunk)	<5	+	+	+		+	+	
14 bronchial carcinoma	<5	+						
6 acromegaly	0			+				
8 breast lump	0	+						
10 osteoporosis	0							
11 agoraphobia	0							
Dementia (Beauchamp and Childress)			+	+		+	+	+

Values-free diagnosis?

Fulford and Hope (1994), in their article, offer a series of linguistic indications (i.e. J.L. Austin-type indications) that the half-field view of the Beauchamp and Childress approach is none other than the half-field of the *medical* model. These are summarized in the next reading.

EXERCISE 8 (30 minutes)

Read the second extract from:

Fulford, K.W.M. and Hope, T. (1994). Psychiatric ethics: a bioethical ugly duckling? Chapter 58 In *Principles of Health-care ethics* (ed. R. Gillon and A. Lloyd). Chichester, England: John Wiley and Sons, (Extract pp. 688–689.)

Link with Reading 8.4

Note:

- the several linguistic indications that Fulford and Hope find in Beauchamp and Childress' account of an implicit medical model; and
- the further indication that this model, as implicit in Beauchamp and Childress' thinking, specifically excludes values from psychiatric diagnostic assessment.

Beauchamp and Childress, then, Fulford and Hope point out, despite noting the value-laden nature of judgements of rationality, draw an explicit contrast between such judgements and 'medical' diagnoses: value judgements, to repeat Beauchamp and Childress' (1989) key phrase, bring in 'moral *rather than* medical considerations' (p. 84, emphasis added).

Beauchamp and Childress's model is thus essentially Boorse's version of the medical model (Chapter 4, above), with facts at the centre, and values, although recognized to be important, marginalized, pushed out to the edge of the picture. Like Boorse, therefore, Beauchamp and Childress seek to exclude values from medical diagnosis, conceiving diagnosis to be a matter of scientific value-free fact. To the extent, therefore, that judgements of rationality are (as Beauchamp and Childress note) value-laden, such judgements have no place (according to their view) in *medical* diagnosis. We rejected this view in Part I, arguing on linguistic analytic grounds that value judgements are important in all areas of medicine, including diagnosis. The failure of fit between Beauchamp and Childress' criteria and many cases of mental disorder, taken together with their (implicit) adoption of the traditional value-excluding medical model, provides further evidence that values may indeed be important in diagnosis.

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Casuistry (case-based reasoning)

We return to the role of values in psychiatric diagnosis below, in Session 4 of this chapter on Values-Based Practice, and then in detail in Chapters 20 and 21. For now, though, we need to pursue the implications of the conclusion that values are integral to judgements of rationality and hence to decisions about involuntary psychiatric treatment.

At first glance, this would seem to suggest that casuistry will give us a better basis for analysing the ethical issues in this area; however, casuistry brings with it its own values-related dangers.

EXERCISE 9 (45 minutes)

Read the extract from an article by the American philosopher, Loretta Kopelman:

Kopelman, L.M. (1994). Case method and casuistry: the problem of bias. *Theoretical Medicine*, 15: 21–37. (Extract pp. 25–27.)

Link with Reading 18.5

Think particularly about two questions:

1. just why does casuistry work as a method for reaching agreement (you may want to refer back to our discussion of this in Chapter 17)?, and
2. given Kopelman's observations about bias, why does the very power of casuistry make it potentially dangerous in mental health?

Kopelman's (1994) discussion, steering as it does a careful path between supporters and opponents of casuistry, provides a number of important insights into the nature of this approach to ethical reasoning. A key point that she brings out is the extent to which casuistry (along with other methods of ethical and indeed scientific reasoning) is biased by values.

In the case study in this extract, an initially plausible casuistic conclusion (in case A) is reversed when further information, shifting the point of salience, is introduced (in case B). In case B, the values of the family are seen to be salient in a way that, as presented in case A, they were not. In case C, again, yet another conclusion is reached from a third perspective.

Casuistry and a common value system

We noted when we were looking at the objectives of training in ethics that, contrary to the common presupposition, no approach to ethical reasoning can be value-free; even the (important) principle of autonomy reflects a value base (in liberal democracy). And in the case of casuistry, the very *power* of the method, what makes it 'go through', is a *shared value system*. The reason why the members of the President's Commission on Bioethics, in Jonsen and Toulmin's original observation, agreed on *what* ought to be done, is that (despite their different theories about *why* it should be done), they shared a common value system. In Kopelman's terms, then, as in this extract, they shared a common (implicit) understanding of what the cases in question consisted in and what the (ethically) salient features of these cases were.

Casuistry and the case vignette questionnaire

But this is also why casuistry, if used in isolation, is potentially dangerous in mental health. For in mental health, as we have repeatedly emphasized, people's values are characteristically not shred but divergent.

The central importance of differences of values in mental health is well illustrated by the case vignette questionnaire. There is a clear sense in which the very problem of involuntary treatment is a problem of conflicting values. In the extreme, the conflict is between a patient whose central value is (or involves) *not* being treated, and everyone else (doctors, social workers, relatives, etc.) whose shared central value is that the patient *ought* to be treated. A casuistic approach, therefore, operating in isolation, cannot but fail to impose the values of the majority on the minority (the patient). In this situation, therefore, the Jonsen and Toulmin observation of everyone agreeing on what ought to be done, is, at best, hazardously extended to mental health.

In mental health, then, casuistry, although a powerful method of ethical reasoning, needs to be used in conjunction with other, more transparent and discursive, methods. To rely, exclusively, on casuistic reasoning, is as likely to endorse as to prevent abusive practices in mental health, to the extent that such practices consist in the imposition of one group's or one person's values on others.

Perspectives

Both the principles approach and casuistry, applied to involuntary psychiatric treatment, have brought out for us the central place of values in mental health. The principles approach, useful as it is for some kinds of mental disorder (e.g. dementia) fails to help with major areas of functional disorder (as in the case vignette questionnaire), essentially because, in adopting a medical model, a 'right-half-field' view of the conceptual structure of medicine, it excludes (diagnostic) values. Casuistry includes values, its very power, as a method of ethical reasoning, being derived from shared value systems. But this means that, given the essentially divergent values characteristic of mental health, casuistry carries with it serious risks of abuse through the imposition of majority values on minorities.

Perspectives and involuntary psychiatric treatment

If, then, values are central, this brings us directly to the importance of perspectives in mental health ethics. Even perspectives, though, are no sinecure! (Notice, by the way, how mental health ethics is already emerging as the trickiest and intellectually most challenging area of health-care ethics.) One problem with perspectives, you will recall, was a danger of relativism, of 'anything goes'. We have seen earlier in the book, that 'anything

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goes' is not what follows from acknowledging the central place of values in the conceptual structure of medicine, and we will return to this at several points later on. But in the case of involuntary psychiatric treatment, where casuistry carries a risk of the values of the majority being imposed on the patient, perspectives carries the opposite risk, of the patient's values being imposed on the majority.

The tension here, between the values of the patient and the values of others, has, and continues to be, played out in an often tragic way in mental health (Robinson, 2003). We return to this in Session 3, in a discussion of rights and responsibilities, and at several points later in the book. But it is important at this stage to understand exactly why the perspectives approach, if unsupported by other methods of ethical reasoning, fails on the centrally important issue of involuntary psychiatric treatment.

Perspectives, insight, and psychosis

The essential difficulty with the perspectives approach in relation to the ethics of involuntary psychiatric treatment, is precisely that, from the patient's perspective, there is nothing psychologically wrong with them. This is captured in the core psychopathological notion of 'loss of insight'. In psychotic disorders, as we saw in Chapter 3, there is 'loss of insight'. That is to say, in psychotic disorders, insight is lost in the specific sense that from the patient's perspective, what is wrong is not that they are ill but that something is being done to them (e.g. with persecutory delusions) or that they have done something (e.g. with delusions of guilt).

We may, with the antipsychiatrists, see this as sufficient justification for avoiding involuntary psychiatric treatment altogether. But this simply denies (rather than giving an account of) the widespread intuition that in some cases involuntary treatment is not only justified but ethically obligatory.

A balanced perspective

Perspectives, then, lead us back to the key ethical significance of the concept of psychosis. Before leaving perspectives, though, it is important to see just how much this approach can contribute. This is brought out in what has justly become a classic in the developing tide of research and narrative reports on user experience, Ann Rogers, David Pilgrim and Ron Lacey's (1993) *Experiencing Psychiatry*. In this book the authors describe the results of a survey carried out on behalf of the patients' advocacy group MIND (now called the National Association for Mental Health). Chapter 5 is concerned with users' views of treatment. On an antipsychiatry model of the relationship between professionals and patients, we might expect rejection of drug therapy out of hand, especially where this is part of involuntary treatment. And there is certainly much evidence of failures of professional-led research to recognize the adverse effects of many commonly prescribed medications. But the chapter evidences a point that has been made repeatedly by those who use services about values in mental health care. The point is not whether to accept a particular treatment, a particular medication, say. It is not, even, whether involuntary treatment may or may not be justified. It is, rather, the extent to which the values of the individual concerned are built into the way in which decisions about these important issues are made.

Most users of services, though certainly not all, do not reject drug treatment as such. But there are vitally important issues from the user's perspective as an individual with a unique set of values which are (often needlessly) neglected in the way decisions about such issues are actually made (the importance of side-effects, in particular, is often largely neglected).

Conclusions

In this session, we have looked at some of the applications to mental health of the three main methods of ethical reasoning employed in bioethics as it has developed as a relatively distinct discipline, principles, casuistry, and perspectives.

All three methods, although carrying risks particularly if used in isolation, are important in mental health: principles for the open framework of discursive argument they supply; casuistry for the power of case-based reasoning to attach ethical arguments to the realities of day-to-day care; and perspectives for the focus they give to the (logically) essential place of the values of the individuals concerned. In the next session, we look at the role of general ethical theory, in which bioethical reasoning has its origins, for mental health.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What are the 'four principles'?
2. How is treatment without consent justified by the 'four principles'?
3. How well do the four principles explain the response pattern for the case vignette philosophical fieldwork exercise in Chapter 17?
4. Why does casuistry 'work' as a method for resolving ethical difficulties?
5. Why does the way casuistry works make it a potentially dangerous tool for ethical problem solving in mental health (if used unreflectingly)?
6. Why are 'perspectives' not a panacea in mental health ethics?

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Session 3 Philosophical ethical theory

The three forms of ethical reasoning examined in the last two sessions—principles, casuistry, and perspectives—have not been invented out of the blue. They reflect long-standing traditions in general ethics.

It is important to be aware of these traditions. First, although further from the coal-face of practice, they offer a range and depth of argument that underpins the more pragmatic tools of bioethics. Second, and following on from this, the more abstract philosophical approaches can help to extend the tools of bioethical reasoning from the relatively straightforward problems raised by technological medicine, for which they were invented, to the more complex questions raised by primary care and mental health.

Substantive and analytic theories

Philosophical ethical theory has been of two main kinds, which we can call substantive and analytic. Substantive theories are concerned with the most general kinds of consideration that are relevant to establishing ethical conclusions. Analytic philosophical ethics is concerned with the meanings and implications of value terms and the general logical form of ethical argument. In this section we will be looking first at substantive theories, and then going on to consider the role of analytic ethics, in both cases with a particular eye to mental health.

EXERCISE 10 (20 minutes)

Before going on, go back to the cases and the arguments that we considered in the last session, where we used the three bioethical approaches of principles, casuistry, and perspectives.

Think about how these approaches could themselves be justified by reference to more general ethical ideas. What is 'good' about the principle of autonomy, for instance? Or why, thinking casuistically, is the suicide risk in Mr AB's case, for example, ethically relevant? (i.e. why would it be relevant to imagine his case without this risk). Again, what is important ethically about recognizing the values inherent in Mr AB's perspective, even though, clinically, he 'lacked insight'?

As before, write down your thoughts about these questions before going on. Remember that it is the general kinds of ethical consideration with which we are concerned here, not the particulars of individual cases.

Substantive ethical theories: deontology and consequentialism

In discussions of the questions raised in Exercise 10, two rather different kinds of consideration usually emerge, corresponding broadly with two major traditions in philosophical ethics—duties and consequences.

Duties and consequences

Duty-based ethics and consequentialist ethics are the two main kinds of substantive ethical theory. They have been variously named (duty-based ethics is sometimes called 'deontological' ethics, for example), but broadly speaking they can be characterized thus:

- *Duty-based ethics*. Duty-based ethical theories, as the name implies, seek to define duties that are incumbent upon people no matter what the consequences might be. Duties are closely linked with rights and responsibilities, and also with law.

  Thus, in Mr AB's case, the professionals could be said to have a duty to treat him under the Mental Health Act. This duty arises from the rights of the patient (and others) to protection, and the responsibility of the professionals to provide such protection. If they fail in this they could be held negligent in law, and so on.

- *Consequentialist ethics* seek to base ethical conclusions on the consequences of the various possible courses of action. The best-known consequentialist ethic is untilitarianism, the slogan for which is the well known 'the greatest good of the greatest number'.

In Mr AB's case, consequentialist arguments for treating him under the Mental Health Act could include his future happiness, avoiding the tragedy for his family of suicide, and so forth.

Both kinds of substantive theory lie behind and underpin bioethical reasoning.

All for one and one for all

At first glance the principles approach is closest to duty-based ethics. Mr AB had a 'right' to treatment, which the professionals had a 'duty' to give—hence the principle of beneficence. Equally, though, Mr AB's right to 'bodily integrity' would normally stand in the way of medical treatment against his wishes—hence the principle of autonomy.

Consequences, on the other hand, seem at first glance more closely relevant to casuistry and to perspectives. Reasoning casuistically, for instance, it is relevant to imagine Mr AB's case without suicide risk because suicide, to the extent that it is a consequence of failing to treat him on an involuntary basis, is so disastrous an outcome that it outweighs the adverse effects of treating him against his wishes. Similarly, though, even if such treatment is ethically right, the best action (as the article by Rogers *et al.*, 1993, in the last session showed) will be determined by whether or not it is carried through with an understanding of Mr AB's particular perspective.

Closer inspection shows, however, that the ethical territory is not so sharply divided between duties and consequences as all that. Autonomy, as a principle, is justified not only deontologically but also by the good outcomes of respecting people's wishes (the principle of non-maleficence is *primarily* justified by the importance in medicine of avoiding *bad* outcomes). Conversely,

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casuistic reasoning must have regard to duties; and the duties that individuals recognize are crucial to their perspectives.

Duties, consequences, and bioethics

So, both kinds of substantive ethical theory are important to the underpinning of all three main approaches to ethical reasoning in bioethics. And the two substantive theories are not, of course, incompatible. Indeed, they are often complementary. The Oxford philosopher, R.M. Hare, on whose work we drew in Part I, makes this point specifically in relation to medical ethics, in his 'Medical ethics, can the moral philosopher help?' (Hare, 1993a, pp. 1–14). As Hare nicely puts it in this article, if the moral philosopher cannot help with medical ethical difficulties, he or she ought to 'shut up shop'. This is because medical ethical difficulties are so typical of the kind of problems with which moral philosophers have traditionally claimed particular expertise.

Moral philosophy, moreover, as we have noted, offers two powerful approaches to reasoning about ethical problems, duty based and consequentialist. These might, perhaps, sometimes be seen as competing ethical theories. But this, Hare says, is certainly not so in medicine. For the two kinds of theory are applicable, respectively, at two different levels of ethical reasoning, the *intuitive* and the *critical*. We noted these two levels in Chapter 17 (where we used Hare's terminology of Level 1 and Level 2 reasoning). His point, here, is that duty-based theories are particularly relevant to the intuitive 'guts feel' response which must guide us in the hurly-burly of day-to-day practice, whereas consequentialist theories are particularly helpful when we stand back and reflect critically on what ought to be done.

Duties, consequences, and analytic ethics

Hare (1993a) also argues in this paper that, with a proper understanding of the meanings of moral words, duty-based and consequentialist theories can be effectively combined in medical ethical reasoning. We touched on his theory that moral judgements are 'universal prescriptions' in Part I (in the discussion of descriptivism and non-descriptivism).

This part of his article is thus concerned with analytic ethical theory. We will return to analytic ethics shortly in relation to psychiatric ethics. First, though, we need to think briefly about the advantages and disadvantages of the two kinds of substantive ethical theory in mental health.

Duties and mental health

There are advantages and disadvantages of both kinds of substantive ethical theory for mental health ethics. The deontological approach is valuable especially where it is necessary to protect the rights of vulnerable groups (such as the mentally ill). However, the legalistic tendencies of deontology, can often make it excessively bureaucratic and rule-bound in practice.

Thus, Jonathan Montgomery, a British lawyer who has worked particularly on the role of rights in medicine and psychiatry, has examined the strengths and weaknesses of rights-based thinking for the development of patient-centred care in his 'Patients first: the role of rights' (1996). In this article, Montgomery notes that rights (with their corresponding duties) can provide important protections against other people's vested interests and, indeed, their well-intentioned interference. But rights talk is not enough. Too often rights are prescribed, particularly by politicians, as a substitute for providing what people really need—Montgomery cites the UK's Patients' Charter as a case in point. Rights, therefore, need legal teeth. But the danger of this, as Montgomery goes on to describe, is that genuine care can all too easily become tied up in bureaucratic knots. So, patient-centredness in health care requires rights with teeth but a balance must be maintained with the professional's freedom of right action.

Consequences and mental health

Consequences are not without their problems either, though. Consequences do force us to look squarely at the facts. But they leave us exposed to the ever-present danger of the 'abuse of casuistry', of the facts being fitted to suit what one would *like* to be done rather than what *ought* to be done!

An interesting attempt to use utilitarianism in health-care ethics is the QALY approach to resource allocation. This approach aims to make the balance of utilities more objective by basing it on the expressed utilities of the parties to the decision-making process. A QALY is a 'Quality-Adjusted Life-Year'. The idea is simple enough. Ask a number of people to rank different kinds of disease and disability in terms of seriousness, weight them for duration, and you have a basis for equating the relative costs of the implied utilities.

The Oxford philosopher, Roger Crisp, was among the first to point out some of the adverse consequences of what he calls in the next reading this 'Totting-up conception' for mental health.

EXERCISE 11 (45 minutes)

Read the extract from:

Crisp, R. (1994). Quality of life and health care. Chapter 13 In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press. (Extract p. 181.)

Link with Reading 18.6

- What can go wrong when the (prima facie eminently reasonable) QALY approach is applied to mental health, according to Crisp?

Crisp (1994) reviews in this article a number of unacceptable consequences of balancing utilities in the way required by the QALY approach. The particular unacceptable consequence outlined in this extract is that, despite its promise of fairness, the QALY approach leads to consequences that, applied in the mathematical way it requires, *excludes* considerations of fairness. Even accepting that the 'severely mentally defective' have a very low

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quality of life (a point that those concerned with caring for this group would contest), considerations of fairness would normally imply that we increase, rather than as the QALY approach requires, withdraw resources from this group.

QALYs as a utilitarian calculus

Mental disorder is also unglamorous, in the public image at any rate. It is much easier to raise 'votes' for eye disease, for example, or cancer research. Hence, the mentally ill, already disadvantaged, are further disadvantaged in any 'one-QALY, one-vote' system.

But perhaps the most serious difficulty with the QALY approach is a difficulty behind all utilitarian calculations, that of imaginative identification with other people's (or our own future) states. As noted above, there may be many different views about the quality of life of a person with severe learning difficulties. Here the problem is compounded by the difficulty they may have in speaking for themselves. But the utility of a year with, say, cancer, as measured by someone suffering from the disease, may be very different from what anyone without the disease would imagine. Indeed, as we will see in the last session in this chapter, we have every reason (from philosophical and sociological work on values) to believe that the actual and imagined utilities will be very different.

This is not to say that QALY thinking is all wrong. After all, squaring health service budgets, balancing needs with resources across a wide spectrum of very different conditions, is impossibly difficult. We need all the help we can get with health economics, which is what QALYs were designed for. But QALY thinking, without the balancing of rights expressing the needs especially of the disadvantaged, leads to serious injustices.

Duties, consequences, and mental health

The importance of balancing duty-based and consequentialist thinking in mental health is nicely illustrated by recent developments in mental health legislation in Europe. This was the subject of a comparative study carried out by one of us (KWMF) with Tony Hope in Oxford, in a research programme led by the German psychiatrist, Professor Dr Hanfred Helmchen, within the European Community (Fulford and Hope, 1996).

As Fulford and Hope showed, the driving motivation behind recent developments in mental health law in Europe has been to protect people with mental illness (conceived as a vulnerable group), from the misuse of the psychiatrist's powers of involuntary restraint and treatment. This, in itself, is vitally important. There is a clear imbalance of power between doctor and patient which, as recent experience in France, discussed in Fulford and Hope's study, shows, is not always adequately redressed merely through the assertion of a voluntary code of ethics.

As the study also showed, however, in protecting rights through legal powers, there is a danger of an excessively bureaucratic and legalistic approach to clinical work emerging, in which the patient, as the holder of 'legal rights', nevertheless fails to get satisfactory treatment. The French philosopher, Ann Fagot-Largeault's phrase, cited by Fulford and Hope (1996), sums this up. Patients, she notes, can now literally run away before the legal process is completed. So the *consequences* of an excessively legalistic approach, designed as it is to protect patient's rights, may be to impair the professionals' powers of action to the point where they are unable to carry out their *duties* adequately.

This is not to say that in any given situation this or that approach is right—perhaps it is a good thing that patients can 'run away'! But as we will see in Chapter 20, the unbalanced hegemony of any one perspective, however well-intentioned, is ever at risk of leading to abusive practices. One way to avoid such imbalances is by weighing up duty-based and consequentialist ethical considerations, rather then treating either as primary. Another, complementary, way, is to recognize the importance of analytic considerations in ethical reasoning.

Analytic ethical theory

Analytic ethics

Analytic ethics, concerned with the meanings of moral and other value words, has been given a hard time recently in philosophy (recall Bernard Williams in his *Ethics and the Limits of Philosophy*, 1985, in Part I). Philosophers, concerned to be seen to be contributing directly to practical issues, have turned away from questions of meaning to questions of substance. But were they right to do this?

EXERCISE 12 (15 minutes)

Go back to the cases we have been considering. How far do either the tools of bioethics or those of substantive philosophical ethics resolve the issues they raised?

We noted in Chapter 17 that it is in the nature of ethical questions that at some point we may reach an impasse. But do the approaches we have considered thus far even bring us to the core of the ethical difficulties and dilemmas that arise in mental health? Is there something important missing?

The missing factor is the meanings of the terms in which the dilemmas and disagreements are couched. Analytic ethics has focused traditionally on the most general of *ethical* terms, like good, duty, responsibility, and so forth. In the case of mental health, crucially important also are the most general of *clinical* terms, disease, disorder, and, not least, mental illness.

The concept of mental illness and bioethics

This brings us back to the importance of conceptual difficulties in mental health ethics, as spelled out in Chapter 17. Mr AB's involuntary treatment, for example, to the extent that it was justified ethically, turned on him being, not merely at risk, nor merely at risk as a result of being sad, nor even at risk as a result of being sad on the basis of a false belief (that he had brain cancer). The critical ethical consideration was that he was at risk as a result of a psychotic mental illness.

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Similarly in the case vignette study, involuntary treatment as an option mapped, not on to the Mental Health Act as such, nor on to the bioethical principles of autonomy and beneficence as such, but on to these only as and in so far as they incorporated the notion of psychosis. Just how 'psychosis' should be understood, moreover, turned out to be highly problematic—even the sophisticated analysis of irrationality offered by Beauchamp and Childress (1989) was consistent only with certain types of psychotic mental disorder (such as dementia).

The concept of mental illness: from substantive to analytic ethics

As we noted a moment ago, analytic ethical theory has traditionally been concerned with the meanings of the most general value words, 'good', 'duty', and so forth. (Of course, analytic philosophy as a whole has ranged far more widely, see Chapter 6.)

The general moral words were very much the focus of R.M. Hare's work, as one of the leading analytic ethical philosophers of the twentieth century. In the next reading, we come to the second of two articles he wrote applying his theory (that moral value judgements are universal prescriptions) to ethical problems in health care. In Exercise 8, earlier in this session, we looked at the first of these articles. In this he argued that his 'universal prescription' theory reconciled duty-based and consequentialist approaches to medical ethical problems. In the next reading, Hare extends this approach to psychiatric ethics, taking involuntary psychiatric treatment as a case in point.

EXERCISE 13 (60 minutes)

Read the extract from:

Hare, R.M. (1993b). The philosophical basis of psychiatric ethics. Pages 15–30 In *Essays on Bioethics*. Oxford: Clarendon Press. (Extract pp. 28–29.)

Link with Reading 18.7

Think carefully about Hare's argument for excluding analytic considerations, other than those concerned with the moral words. Thus, he argues earlier in the article that the concept of 'person' is irrelevant, or certainly not critical, to the ethical issues raised by abortion; and in this extract, similarly, that the concept of 'disease' is not critical to the ethical issues raised by involuntary psychiatric treatment. But is he right?

In this extract, Hare (1993b) turns to the topic that will occupy us in detail in Chapters 20 and 21, namely the diagnostic problem, the problem of whether this or that medical condition is properly understood as a disease. Unlike the many authors reviewed in Part I of this book, Hare takes it as self-evident that disease is an evaluative concept. It comes as something of a surprise, then, given the importance to us of Hare's conceptual work in Part I, that in this extract he dismisses the relevance of analytic philosophy to settling questions about the disease status of particular conditions. He has, he implies, settled the relevant analytic question (that disease is an evaluative concept), and he believes that the work of analytic philosophy, in psychiatric as in other areas of medical ethics, is to be done exclusively in terms of the general moral words (good, ought, etc.).

Right answers from philosophy?

Elsewhere in this article, and in other publications from his later output (e.g. Hare, 1981), Hare (1993b) shows how an understanding of the logic of the moral words (derived from analytic philosophy), combined with plausible assumptions about people's values, can provide a rational basis for debate about moral problems. Applying this approach, however, as he does in this extract, to the diagnostic problem in mental health, risks abusive consequences. It will be worth pausing on why this is so. As an analytic philosopher, and one for whom the evaluative element in the meaning of disease and related concepts is self-evident, understanding precisely why Hare's restriction of analytic methods to the general moral words risks abusive consequences in mental health, will provide an important link to the rather different use of analytic philosophy that we will be making in the last session of this chapter, as the basis of Values-Based Practice.

Thus, the crucial question, Hare says in the extract linked with Exercise 13, in coming to a conclusion about whether this or that condition is a disease, is whether the condition in question (homosexuality and political revisionism are his two examples) is a condition of which we 'approve' (p. 29). Whether we *should* approve of a given condition in turn depends, according to Hare's method of reasoning, on whether those concerned consider that 'treatment to remove [their condition] will on the whole be for the best for [them] and others' (p. 29). As to involuntary treatment, he continues, this 'can only be justified by large countervailing gains (e.g. in the protection of the public from dangerous mental patients)'. And '. . . It is hard to see what those gains could be . . . [for homosexuality and political revisionism]' (all p. 29).

Up to a point, then, Hare's account must be right. If, as he says, disease is an evaluative concept, what we take to be a disease necessarily involves (in part) value judgements. But the risks of abusive consequences become clear when we consider the particular way in which Hare suggests the relevant value judgements are to be made, i.e. by relying on societal consensus. True, he refers, first, in respect of voluntary treatment, to the values of those concerned. But even here, the relevant value judgement is whether treatment to remove their condition will '*on the whole* be for the best for [them] *and others*' (p. 29, emphases added). So, it is by the values of people in general that we should be guided as to whether voluntary treatment should be given (and hence disease status ascribed). The role of societal consensus is still more explicit in respect of involuntary treatment. For in this case, the 'large countervaluing gains' by which, in Hare's approach, involuntary treatment is justified, are illustrated by 'protection *of the public* from *dangerous* mental patients' (p. 29, emphases added); and who, in Hare's account, is in a better position to judge what is 'dangerous' to the public than the 'public' themselves?

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We can understand Hare's reliance on societal consensus as being driven by his (perceived) need to derive substantive conclusions from his analytic moral philosophy. You will recall from Part I that analytic philosophy came under attack over the period in which Hare was writing, for being practically impotent. Hare himself, analytic philosopher though he was, felt obliged to argue that an understanding of the logic of the moral words (derived from analytic philosophy), combined with information about the values that people actually hold, leads to conclusions that are to all intents and purposes definitive 'right answers' to moral problems. In the Introduction to his 1981 book, for example, on 'Moral thinking: its levels, method, and point', he makes this explicit: '. . . I shall be maintaining', he writes, 'that, if we assumed a perfect command of logic and of the facts, they would constrain so severely the moral evaluations that we can make, that in practice we would be bound all to agree to the same ones' (Hare, 1981, p. 6).

From right answers to good process

Yet it is precisely this assumption of 'right answers', of values to which everyone is 'bound' to agree, that is challenged by the diversity of values in mental health. In Session 4 (and again in Chapters 20 and 21), we will be looking at the practical consequences of taking seriously the *analytic* tools of analytic philosophy in the form of Values-Based Practice. The idea behind Values-Based Practice is to provide a toolkit for reasoning about values in health care in circumstances in which, far from there being a consensus, values are highly diverse. In developing this toolkit, analytic philosophy, as we will see, shifts our attention from 'right answers' to 'good process'. And 'good process', we will argue, far from being practically impotent, is highly effective practically where values conflict. And good process is effective, furthermore, while avoiding, or at any rate limiting, the risks of abuses arising from the imposition of one individual's or group's 'right values' on those whose values are different.

The importance of 'good process' rather than 'right values' in mental health will already be clear: mental health, as Hare's analytic work in particular (on the general moral or value words) helped us to see in Part I, is an area of health care in which human values are highly diverse. Hence mental health is an area in which societal consensus, if the sole basis on which judgements of health and disease are made, is at risk of abusive consequences. This is why Hare's initially plausible analysis is at risk of generating just the abusive consequences he would have been at pains to prevent.

But are these abusive consequences merely theoretical? Or do they occur in practice? We will look briefly at this question (we return to it in Chapters 20 and 21) before turning to an introduction to Values-Based Practice in Session 4 of this chapter.

Analytic ethics: from theory into practice

Hare was not alone in failing to recognize the importance of the concept of mental illness in psychiatric ethics. Indeed, the divorce between ethical and conceptual issues in mental health is well-illustrated by an extraordinary divide that there has been in the literature generally between, on the one hand, bioethics (as covered in this part of the book), and, on the other, the debate about the concept of mental illness (as covered in Part I).

This divide, into ethical and conceptual strands, is a good example of the pervasive influence of a (generally implicit) biomedical model. We saw in Chapters 2, 4, and 6 that the medical model was highly influential on the form of the debate about mental illness, restricting its terms of reference to whether or not mental illness could be directly mapped on to what was assumed to be a paradigmatically value-free concept of bodily illness. In this chapter, similarly, we have found that essentially the same model has been operating in bioethics (in Beauchamp and Childress, 1989, for example).

Practical consequences

Just how deeply mistaken the divorce of ethical and conceptual issues may be from a practical point of view, is illustrated by the next reading (Fulford *et al.*, 1993).

This article was the result of a collaboration between one of us (Fulford), a Russian psychiatrist (Smirnoff), and a Russian-speaking social worker (Snow). These three authors set out to examine the extent to which the concepts of disorder current in the former USSR over a period when abusive uses of psychiatric diagnosis became widespread, differed from those prevalent in the 'West'. As the article describes, the analysis was based on a survey of the literature on concepts of disease in Russian-language academic journals.

EXERCISE 14 (60 minutes)

Read the two extracts from:

Fulford, K.W.M., Smirnov, A.Y.U., and Snow, E. (1993). Concepts of disease and the abuse of psychiatry in the USSR. *British Journal of Psychiatry*, 162: 802–803

Link with Reading 18.8

The readings describe the findings from the authors' review of Russian-language journals:

- What strikes you about the Soviet literature on concepts of disease from this period?
- What model does it reflect?

The institutionalized abuse of psychiatry in the former USSR provoked a considerable literature at the time in the West, much of it overtly ethical. This literature, however, was, in effect, concerned with the factors that allowed abusive practices to become widespread (unbalanced political power, poor standards of training, and so forth). It thus failed to consider why psychiatry, rather than, say, surgery, should be vulnerable to abuse in the first place. Insofar as this was considered at all, it had been assumed that it was due to diagnoses of mental disorder being made on the basis of inadequate clinical examination and/or defective science.

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This of course is a reasonable assumption given a scientific medical model of disorder. As the authors of this paper show, however, Soviet psychiatry was operating with a model of disorder which was if anything *a more hard-wired scientific medical model* than those being employed at the time in western Europe and America. The themes of the Soviet literature, as described particularly in the second extract, are very similar to those around the 'medical' model even today. I.V. Davidovskii, in particular, whose ideas dominated this period (from his first major publication in 1962), was a pathologist. His strongly biological concept of disease directly influenced ideas on schizophrenia as a 'biological' disorder. He published a joint paper with the originator of the Soviet concept of 'sluggish schizophrenia', A.V. Snezhnevsky (Davidovskii and Snezhnevsky, 1972).

The authors explore a number of interpretations of this finding and conclude that, far from an unscientific model of mental disorder being the origin of Soviet psychiatric abuse, a spurious scientific authority was given to diagnoses of severe mental disorder made on the basis, merely, of political deviance as judged by the dominant Soviet values of the day.

As has several times been noted, findings of this kind do not undermine the place of science in mental health. To the contrary, such findings graphically illustrate the need for a full-field view of the conceptual structure of the subject, incorporating facts, but also values, on an equal basis, as outlined in Chapter 6. It is to the practical consequences of this full-field view, drawing on the resources particularly of analytic ethical theory, that we turn in the concluding session of this chapter. We return to the role of values in psychiatric diagnosis in Chapters 20 and 21.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What is deontology? And where is it used in practice?
2. What is consequentialism? And where is it used in practice?
3. What is analytic ethics?
4. Why is analytic ethics important especially in mental health? What extra 'tools' does it deliver?
5. What is the key shift of thinking about ethical issues that is required if we are to draw equally on analytic as on substantive ethical theory to derive 'tools' for ethical reasoning in practice?

Session 4 Values-based practice

In this session we outline the 10 principles of Values-Based Practice, or VBP, as a contribution to the values toolkit of health care.

VBP is a response to the growing complexity of health-care decision-making. In this respect it is like evidence-based practice, or EBP. VBP and EBP, as we will see, are complementary: EBP is a response to the growing complexity of the facts bearing on health-care decision-making, VBP is a response to the growing complexity of the corresponding values. VBP, then, is the theory and skills base for effective health-care decision-making where different, and hence potentially conflicting, values are in play.

Aim: extending the toolkit

VBP, although (as we noted in the last session) derived from the somewhat abstract concerns of analytic philosophical value theory, has primarily practical aims. As such, we will be emphasizing in this session the many ways in which the practical tools of VBP, derived from philosophical value theory, differ from the predominantly quasi-legal practical tools derived from bioethics.

VBP might in consequence be thought to be anti-ethics! VBP is certainly anti the overuse of the tools of quasi-legal ethics—as we saw earlier in this chapter, overuse of such tools leads to untoward consequences for health care (remember the three '-flations', code inflation, practitioner deflation, and problem conflation). But it is no part of VBP to suggest that we can do without a framework of law and codes of practice altogether. To the contrary, the tools of quasi-legal ethics, used where they are 'fit for purpose', are essential: and the theory of VBP, as we will see, helps to define where and how the tools of quasi-legal ethics are indeed fit for purpose.

VBP, then, is about supplementing, not supplanting, quasi-legal ethics. VBP is not about throwing out the tools of quasi-legal ethics from the values toolkit of health care. VBP is about adding new tools.

Structure of the session

This is a long session but it is divided into five sections covering, respectively, the premiss and 10 key principles of VBP, the latter as summarized in Box 18.1. Briefly, then, the sections run thus:

1. *Ethics, values, and mental health* draws on earlier parts of the book to derive the distinctive premiss of VBP. Traditional ethics starts from a presumption of 'right' values, VBP starts from the 'democratic' premiss of respect for differences of values. Consistently with its democratic premiss, VBP relies of 'good process' rather than prescribed 'right outcomes' for its effectiveness as a contribution to the decision-making toolkit of health care. Good process in VBP is summarized in the 10 principles shown in Box 18.1 and described in the rest of the chapter.
2. *VBP and EBP* (principles 1–3) defines three key principles of the strongly interdependent relationship between VBP and EBP as decision support tools for health care.
3. *VBP and new models of service delivery* (principles 4 and 5). Like ethics, VBP starts from patients' values (Principle 4); but

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it adds to these the values of others, including professionals, seeking a balance of values, in particular through multidisciplinary models of service delivery (Principle 5).

4. *Training initiatives* (principles 6–9): this section shows how the effective application of Principles 4 and 5 in turn depends on four key areas of clinical skill, awareness (Principle 6), knowledge (Principle 7), reasoning skills (Principle 8), and communications skills (Principle 9).
5. *VBP, EBP, and a new alliance in health-care decision-making* (principle 10): the final section returns to the relationship between values and evidence in clinical decision-making. Principle 10 of VBP is about 'who decides?' It shifts the locus of control in health-care decision-making from external experts (such as lawyers and ethicists) to those directly concerned in a given decision—patients, carers, health professionals, voluntary workers, managers, policy makers, etc. Combined with EBP, this VBP shift is the basis for a new and more positive alliance between users and providers of services.

Box 18.1 Ten principles of values-based practice

Values-based practice and evidence-based practice

1st Principle of VBP: the two feet principle

All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis

2nd Principle of VBP: the squeaky wheel principle

We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic

3rd Principle of VBP: the science driven principle

Scientific progress, in opening up choices, is increasingly bringing the full diversity of human values into play in all areas of healthcare

Values-based practice and service delivery

4th Principle of VBP: the patient-centred principle

VBP's 'first call' for information is the perspective of the patient or patient group concerned in a given decision

5th Principle of VBP: the multidisciplinary principle

In VBP, conflicts of values are resolved primarily, not by reference to a rule prescribing a 'right' outcome, but by processes designed to support a balance of legitimately different perspectives

Values-based practice and clinical practice skills

6th Principle of VBP: raising awareness

Careful attention to language use in a given context is one of a range of powerful methods for raising awareness of values

7th Principle of VBP: knowledge

A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people's values

8th Principle of VBP: reasoning

Ethical Reasoning is employed in VBP primarily to explore differences of values, not, as in quasi-legal bioethics, to determine 'what is right'

9th Principle of VBP: communication

Communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in VBP

Values-based practice, evidence-based practice, and a New Alliance

10th Principle of VBP: who decides

VBP, although involving a partnership with ethicists and lawyers (equivalent to the partnership with scientists in EBP), puts decision-making back where it belongs, with users and providers at the clinical coal-face

1) Ethics, values, and mental health

In health care, values are generally equated with ethics. Why, then, is this session called 'Values-Based Practice' not 'Ethics-Based Practice'? Values and ethics are related in *some* way. But how? How are they similar? How are they different?

For values read ethics?

These are questions we might have raised in Part I, in our work on values and their roles in shaping the core concepts of health care—illness, disease, dysfunction, and so forth. We drew in Part I on certain general logical properties of value terms as teased out by Hare, Warnock, and others, working in a tradition of philosophical value theory, the so-called 'is-ought' debate, running from Hume's dictum 'no ought from an is'.

Yet philosophical value theory, although concerned in principle with the meanings and implications of *value terms in general*, has in practice focused mainly on *ethics*. Even Hare (1952), who sets up an expressly analytic philosophical agenda in his *The Language of Morals*, is mainly concerned to define specifically ethical (or moral) values (as *universal* prescriptions). And in Hare's subsequent work,

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the examples he uses, the problems he tackles, and the conclusions he draws, are all largely concerned with ethics.

The 'is-ought' debate, it is true, has recently been extended to economics: recall Roger Crisp's (1994) analysis of QALYs earlier in this chapter; and in economics generally, note the work of the Nobel prize-winning economist, Amartya Sen (1987). Again, though, the concern has been with essentially ethical questions of justice rather than with wider issues of the roles and functioning of values in general in economics. Aesthetics, similarly, has been pursued largely as a philosophical tradition distinct from ethics. While as to values in science, even as recently as the start of the new millennium, the American philosopher, Hilary Putnam, felt it necessary to emphasize that 'epistemic values are values too' (Putnam, 2002, p. 30)!

Small wonder, then, that in health care, following philosophy, we tend to assume 'for values read ethics.' Why, then, the need for 'VBP'? Why not the more familiar-sounding 'ethics-based practice'? In the next exercise we start to unpack these questions by reflecting on the differences between ethics and values.

EXERCISE 15 (20 minutes)

What are the differences between ethics and values? Write down a few words or short phrases that you associate (1) with 'ethics', and (2) with 'values'.

Don't think too deeply about your two lists. This is not an exercise in philosophical depth analysis! It is a 'word association' exercise intended, in the spirit of Austin's 'philosophical fieldwork', to draw out some of the features of our ordinary uses of these two concepts.

Table 18.4 gives two lists as produced by a small group, some with a background in philosophy, others coming from health care (with both user and practitioner experience). Your two lists may of course be very different. But these are typical. For most groups, two broad themes stand out:

1. *Values are wider than ethics*. As noted above, values includes not only ethics but also aesthetics, economics, and the epistemic values guiding science. To these we might add, values in risk assessment (and 'games theory' generally), prudential values, and so on.
2. *Values are open, ethics closed*. Most people think of values as being 'personal', 'acquired', and 'variable', while ethics are 'impersonal', 'given', and 'invariant'. Thus, in religion, ethical values, although personal in the sense of being owned by an adherent of a given religion, are perceived as being derived from an external authority. In (some) philosophies they are part of a Platonic realm of ideals; they may be fixed by reason (Kant's categorical imperative), or by logic (Hare's 'universal prescriptions').

Table 18.4 One group's responses to Exercise 15 on the differences between ethics and values

Values	Ethics
◆ Personal Emotive Meaningful	◆ Rules Doing the right thing Biomedical dilemmas
◆ Taste Choice Preferences	◆ Something to rely on Rules—certainty Absolutes
◆ Wide range Culture specific Preferences	◆ Professional guidelines Rules Respect for *rights*
◆ Anything important Things Places People	◆ Right and wrong Value-based Guide good decision-making
◆ Subjective Personal judgement Ideals Emotional judgement Worth	◆ Morals Integrity Conduct—'taking a stand'
◆ Social conditioning Emotional judgement Worth	◆ Prescriptions Religion Social coherence
◆ Standards Principles Estimation	◆ Structured study of values Code of conduct Institutional rules

The premiss of Values-Based Practice: respect for diversity

The above is only an approximate characterization, of course, of the different associations of ethics and values. As such, though, the two broad themes explain the importance of *values*-based rather than *ethics*-based practice in health care. As already noted, bioethics is a rich and open-minded discipline at the level of theory. As an academic discipline, therefore, we could say in terms of our two word-association lists, that bioethics is concerned as much with values as with ethics. But the tools derived from bioethics to support decision-making in practice, the quasi-legal tools of codes, regulatory bodies and so forth, reflect the narrower and prescriptive associations of ethics rather than values.

VBP, then, really is about values rather than ethics. It is about values, broadly and inclusively understood, not just about ethical values. It is also open, rather than closed, in the sense that, as noted at the start of this session, it is premissed not on 'right values' but on respect for differences of values.

For our purposes, here, of adding to the decision-making toolkit of health care, the premiss of VBP is sufficiently grounded contingently, i.e. in the given diversity of human values noted in Part I. The premiss has also, though more contentiously, an analytic basis in the distinction between description and evaluation (Fulford, 2004). As we saw in Part I, the 'is-ought' divide is best understood as a distinction rather than a dichotomy. As such, though, the essence of Hume's 'law' is preserved, that from a mere description (however complete), no evaluative conclusion can be drawn. To this extent, then, values, as it were, 'float free' from determination by facts.

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A democracy of values

It is important to recognize that the premiss of VBP, in respect for differences of values, is very far from being empty of practical implications. The justification for a closed impersonal ethic is that without this, we will have no defence against the 'anything goes' chaos of ethical relativism. Well, we saw in Part I that recognizing a role for values is not, in itself, a recipe for chaos because human values, if diverse, are not chaotic. Conversely, we will see in Chapter 21, that it is absolutism, not relativism, that, historically, has been the greater menace in mental health. As the Italian philosopher and historian of science, Paolo Rossi has argued, drawing on the lessons of Renaissance science, we should be ever on our guard against obscurantism (Rossi, 2003). But values as such, and an acknowledgement of the diversity of human values, is not a recipe for chaos in health care decision-making.

One way to understand the move from ethics-based (quasi-legal ethics-based) to values-based decision-making in health care is by analogy with the move from totalitarian to democratic politics. A totalitarian regime—centrally led, top-down, with prescribed values enforced by a secular or religious authority—might seem a stronger system than a democracy in which, by definition, all voices count equally. And a totalitarian regime may indeed be appropriate where overwhelming shared values are at stake—even in a democracy, martial law is declared where survival itself is at stake! But in practice, at least in the complex values-rich environment of industrial and post-industrial societies, it is democracy that has proved the more robust.

From premiss to principles

The move from quasi-legal ethics to VBP is thus in some respects like the move from a totalitarian to a democratic political regime. Like a political democracy, VBP, as a democracy of values, relies, as we noted at the start of this session, on good process rather than on right outcomes to support decision-making in health care.

The 10 principles of VBP, set out in Box 18.1, summarize the key elements of good process in VBP as these relate to health-care decision-making. As Box 18.1 shows, these fall into four groups defining, respectively,

- the relationship between VBP and EBP (Principles 1–3)
- a VBP model of service delivery (Principles 4 and 5)
- four key clinical skills underpinning VBP (Principles 6–9), and
- a shift in the 'locus of control' leading to a new alliance between users and providers of services in health-care decision-making (Principle 10).

We will consider each of these four groups of principles separately in the remainder of this session.

2) Values-Based Practice and Evidence-Based Practice

A central feature of the good process on which VBP relies for its effectiveness in health-care decision-making, is a particularly strong model of the relationship between values and evidence.

This relationship, which is the basis of a new and more positive alliance between stakeholders in health-care decision-making (see Principle 10, below), is defined by the first three principles of VBP.

Principle 1 of Values-Based Practice: the 'two feet' principle

The first principle of VBP—the 'two feet' principle—is that all decisions stand on two feet, on values as well as on facts. So far, so good. To the extent that decisions are based on reasons, they are based on what Aristotle first called 'practical reasoning'. Such reasoning combines, as Aristotle put it, desires (values) as well as beliefs (facts). And modern 'decision theory', similarly, combines utilities (values) with probabilities (facts) (see, eg, Hunink and Glasziou, 2001).

The 'two feet' principle of VBP, however, goes on to make the more contentious claim that fact and value are woven together in *all* decisions, including decisions about *diagnosis*. Here, then, VBP is at variance with the traditional medical model in which, as we saw in Part I, diagnosis is reserved to 'value-free' science. We will be returning to values in psychiatric diagnosis in Chapter 21. But it will be worthwhile reviewing here, briefly, the grounds for VBP's challenge to the traditional medical model on this key point.

EXERCISE 16 (10 minutes)

Skim through earlier chapters of this book and pick out arguments supporting Principle 1 on its claim that even decisions about diagnosis stand on a values-foot as well as the better recognized fact-foot.

Values in diagnosis: an Ariadnean thread

The role of evaluation, alongside description, in diagnostic assessment in health care, runs like Ariadne's golden thread through earlier chapters of this book.[1] It was central to the work we did on concepts of illness and disease in Part I; it emerged again in Part II in the tension in Jaspers' work between value-laden and value-free understandings of psychopathological concepts; and in Part III, on the philosophy of science, it was implicit in the perspectival nature of observation, and explicit in the epistemic values guiding theory choice.

The distinction on which the 'two feet' principle of VBP rests, between fact and value (or, more exactly, description and evaluation), has of course been subject to recent philosophical critiques. As we noted in Part I, these critiques can be understood as the latest moves in the 'is-ought' debate, a debate about the logical relationship between description and evaluation. Such critiques are widely taken to show that the fact-value distinction is illusory, a distinction without a difference. What they actually show, however, is that the distinction cannot be driven all the way back. In Putnam's (2002) helpful terminology, introduced in Part I, the *dichotomy* has collapsed but the *distinction* remains useful.

[1] In classical Greek legend Ariadne escaped from the Labyrinth by following a golden thread that she spun out behind her as she was taken by her captors to be sacrificed to the bull-headed Minotaur monster.

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Putnam's (2002) way of conceptualizing the relationship between description and evaluation, by (loose) analogy with entanglement in quantum physics, is indeed a helpful pointer to Principle 1 of VBP. We summed up Putnam's model in Part I as 'no ought without an is, and vice versa'. Putnam joins with Amartya Sen (1982) in attacking positivist economic models for their illusory assumption of 'is without ought'. Similarly, then, the thrust of earlier parts of this book may be understood as an attack on positivist medical models for their illusory 'is without ought' diagnostic categories.

Principle 2 of Values-Based Practice: The 'squeaky wheel' principle

Principle 2 of VBP is derived from the work we did in Part I about values becoming visible when they are diverse and, hence, may cause trouble. The 'squeaky wheel', as they say, 'gets the grease'. So it is the values that cause trouble that we notice.

We looked in Chapter 6 at R.M. Hare's work on this—remember his example of 'good picture' (values visible) versus 'good strawberry' (values invisible) and how this parallels 'mental illness' (values visible) versus 'bodily illness' (values invisible). We will see in Chapter 21 that similar differences in the extent to which values are agreed upon, underpin the difference between the apparently value-free diagnostic concepts of bodily illness and the overtly value-laden diagnostic concepts of mental illness.

Principle 3 of Values-Based Practice: the 'science driven' principle

A corollary of the standard 'fact-only' medical model is that with future advances in the neurosciences, values will become less prominent in psychiatry, the discipline coming increasingly to look like bodily illness in this respect—remember from Part I that this was a welcome expectation in the minds of those, like R.E. Kendell, who argued that mental illness is essentially no different from bodily illness. VBP has contrary implications.

EXERCISE 17 (20 minutes)

Think about these contrary implications for yourself before going on. In particular,

1. Why should science increase, rather than as the traditional medical model would suggest, decrease, the value-ladenness of medicine?
2. Why should we welcome a future increase in the value-ladenness of medicine rather than joining with Kendell in welcoming a future decrease in the value-ladenness of psychiatry?

One way of approaching these questions is to consider recent developments in an area of bodily medicine, such as reproductive medicine, which has seen dramatic advances in its scientific basis. Has this gone with an increase or a decrease in values-related issues? And why?

The example of reproductive medicine makes the point here. Far from becoming less value-laden, recent dramatic advances in this area—in assisted reproduction, foetal selection, and so forth—have greatly increased the value-ladenness of the discipline. Why? Well, because scientific advances open up a widened range of *choices*, with choices go *values* (Principle 1), and with a widened range of choices goes *diversity* of values, and, hence, greater *prominence* of values (Principle 2).

We should welcome the increasingly value-laden nature of bodily medicine, therefore, as a reflection of increasing patient choice. Whereas, correspondingly, if psychiatry were to become *less* value-laden, as Kendell anticipated, this would reflect *reduced* patient choice.

A Kendell-type outcome, it is worth adding, an outcome in which scientific advance is associated with *reduced* value-ladenness, is always possible in principle. But it is only possible through the results of scientific advance being, somehow, hijacked by one particular interest group. In such circumstances the uses to which the results of scientific advances are put will reflect the values only of that particular group; and the diversity of human values, which is a key aspect of our individuality as unique human beings, will in consequence be squeezed out of the decision-making process.

3) Values-Based Practice and new models of service delivery

In a political democracy good process depends, *inter alia*, on appropriate institutional structures and an open electoral franchise. In VBP, good process depends, *inter alia*, on appropriate models of service delivery developed within an international 'open society' in mental health.

An open society in mental health

VBP, as you might expect, does not prescribe any *particular* model of service delivery! To the contrary, as in a political democracy, the values-democracy of VBP depends crucially on an open and dynamic exchange of ideas and experience at local, national, and international levels.

Good process in VBP, then, depends on what the British psychiatrist, Jim (J.L.T.) Birley, recalling the open society advocated by the philosopher of science, Sir Karl Popper (1962), called an international 'open society' in mental health. Such an international open society, Birley said (drawing on his experience as the founder President of the human rights organization, the Geneva Initiative for Psychiatry), is a defence against the repeated collapse of psychiatric services into abusive practices (Birley, 2000).

In such an open society, then, there is no place for a pre-set centre, a dominant model assuming the moral high ground. To the contrary, in VBP different models of service delivery, adapted to different circumstances and to different times, responsive to local needs, and building on local skills and resources, are a positive resource, a mutual 'learning set' providing checks and balances in a 'continuous evolution' approach to service development.

The NSF model of service delivery

An understandable fear with this open democratic approach, as we noted above, is that in giving up on right answers (or

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'right outcomes' as we called them), we risk 'anything goes'. But substituting good process for right outcomes is no more likely to lead to 'anything goes' in the values democracy of VBP than it is in a political democracy. Box 18.2 illustrates how, through one particular model of service delivery, developed in the UK, the values democracy of VBP may work out in practice.

Box 18.2 The NIMHE Values Framework

The National Framework of Values for Mental Health

The work of the National Institute for Mental Health in England (NIMHE) on values in mental health care is guided by three principles of Values-Based Practice:

1. *Recognition*—NIMHE recognizes the role of values alongside evidence in all areas of mental health policy and practice.
2. *Raising awareness*—NIMHE is committed to raising awareness of the values involved in different contexts, the role/s they play and their impact on practice in mental health.
3. *Respect*—NIMHE respects diversity of values and will support ways of working with such diversity that makes the principle of service-user centrality a unifying focus for practice. This means that the values of each individual service user/client and their communities must be the starting point and key determinant for all actions by professionals.

Respect for diversity of values encompasses a number of specific policies and principles concerned with equality of citizenship. In particular, it is anti-discriminatory because discrimination in all its forms is intolerant of diversity. Thus respect for diversity of values has the consequence that it is unacceptable (and unlawful in some instances) to discriminate on grounds such as gender, sexual orientation, class, age, abilities, religion, race, culture or language.

Respect for diversity within mental health is also:

- *user-centred*—it puts respect for the values of individual users at the centre of policy and practice;
- *recovery oriented*—it recognizes that building on the personal strengths and resiliencies of individual users, and on their cultural and racial characteristics, there are many diverse routes to recovery;
- *multidisciplinary*—it requires that respect be reciprocal, at a personal level (between service users, their family members, friends, communities and providers), between different provider disciplines (such as nursing, psychology, psychiatry, medicine, social work), and between different organizations (including health, social care, local authority housing, voluntary organizations, community groups, faith communities and other social support services);
- *dynamic*—it is open and responsive to change;
- *reflective*—it combines self monitoring and self management with positive self regard;
- *balanced*—it emphasises positive as well as negative values;
- *relational*—it puts positive working relationships supported by good communication skills at the heart of practice.

NIMHE will encourage educational and research initiatives aimed at developing the capabilities (the awareness, attitudes, knowledge, and skills) needed to deliver mental health services that will give effect to the principles of Values-Based Practice.

Box 18.2, gives a National Framework of Values for Mental Health. As you will see, it is very different in form and content from the lists of aspirational values that such 'frameworks' generally consist of.

It was developed by NIMHE (the National Institute for Mental Health in England), the section of the UK's National Health Service responsible for implementing government policy on mental health in England and Wales, as set out in the UK government's National Service Framework for Mental Health (Department of Health, 1999), the National Health Service Plan (Department of Health, 2000), and the Priorities and Planning Framework (Department of Health, 2002).

NIMHE's first action, established by ministerial announcement at its launch conference in 2001, was to launch a Values Project Group, chaired by Piers Allott, an expert in recovery (see e.g. Allott *et al.*, 2002), and reporting directly to NIMHE's Chief Executive, Anthony Sheehan. Over about 1 year, the Group developed the Values Framework and piloted it with potential stakeholders from both user and provider communities. The Framework was published initially in an on-line conference organized by the Group with Toby Williamson and Bernard Fleming of the Mental Health Foundation, a mental health NGO, on behalf of NIMHE, the Sainsbury Centre for Mental Health (see below) and Warwick University (http://www.connects.org.uk/conferences). The framework has subsequently been published on NIMHE's website (see Useful Websites, below) and in hard copy (e.g. National Institute for Mental Health England, The Sainsbury Centre for Mental Health and the NHSU, 2004; Woodbridge and Fulford, 2004).

In the next exercise we look at the VBP features of the Framework. We consider some of the risks it carries with it and how these are reduced or avoided, including in particular the risk of 'anything goes'.

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EXERCISE 18

Read through the Framework shown in Box 18.2. It is explicitly a Framework for VBP. As you read through the Framework, therefore, mark:

1. any VBP principles you can identify, referring particularly to the model of service delivery defined by Principle 4 (patient-centred practice) and Principle 5 (multidisciplinary working);
2. the practical corollaries of VBP that are identified in the Framework; and
3. any indications there are in the Framework itself of how it will be implemented.

Referring, then, to Box 18.2, you will see that the first part of the Framework refers to 'three principles' of VBP, summarized as 3 R's, Recognition, Raising Awareness, and Respect. Clearly, the first two R's correspond closely with two particular VBP principles as shown in Box 18.1: Recognition corresponds with Principle 1, the first of the principles of VBP theory, and Raising Awareness corresponds with Principle 6, the first, and as we will see below, key area of VBP clinical skills.

Principle 4 of Values-Based Practice: the user-centred principle

Respect, the third R, refers mainly to Principle 4 of VBP, namely the 'patient-centred' principle. As in a political democracy, although VBP starts from equality of respect, there are particular contexts, defined by particular relationships, in which particular prominence is given to a particular individual or group. The parent–child relationship is special, for example: it is consistent with democratic processes that parents give particular weight to the interests of their own children. Similarly in health care, then, service user centrality is, as the third R puts it, '. . . a unifying focus for practice'. And '. . . the values of each individual service user/client and their communities must be the starting point and key determinant for all actions by professionals.'

At first glance, this might look like one or another familiar rhetoric: the rhetoric of the politicized 'user movement'; or the rhetoric of bioethical 'autonomy'; or the rhetoric of 'consumerism' in health care. But the wording of the third R, which was drafted by Simon Allard, a user of services who led a major field study of users' values in London before joining the NIMHE Values Project Group, is very precise.

Thus, the third R is not about a hypothetical set of generic service users' values defining a political 'platform' statement. As rhetorical devices, such statements have been important in empowering users. But the wording here, consistently with the VBP premiss of respect for diversity, is about the 'values of each *individual* service user/client and their communities' (emphasis added). Similarly for the rhetoric of bioethics: the third R is not about autonomy, at least as a bioethical principle. An individual's values, on this VBP model, could equally be about *dependence* (as in Alistair Campbell's article, see reading 17.1). As to the rhetoric of 'consumerism', while the third R is indeed user-centred, the wording makes clear that the values of others, including professionals, are important as well. The values of the user are 'a unifying focus', but not an *exclusive* focus; they are a 'starting point', but not an *end* point; and they are a 'key determinant', but not the *only* determinant.

Principle 5 of Values-Based Practice: the multidisciplinary principle

The principle of service user centrality comes in again as the first of the bullet points that appear in the second half of the Framework (see Box 18.2). These bullets, to come to the second question in Exercise 18, spell out some of the specific corollaries for policy and practice of VBP. Here, then, besides user centrality (bullet point 1), the importance of other voices is made fully explicit in the commitment to multidisciplinary working, spelled out in bullet 3. Bullet 3 makes clear that in VBP the premiss of respect is a premiss of *mutual* respect, between users, carers and providers, between different health care disciplines, between statutory and voluntary organizations, and so forth.

This is all very different from the approach of quasi-legal ethics, then: VBP places an onus of respect on users as well as providers of services; it gives weight to the values of providers as well as those of users; and, as we will see in more detail under Principle 10 below, it replaces regulatory control of medicine and science with a partnership model of service delivery.

No 'anything goes' in the NSF

User-centred policy and practice and multidisciplinary models of service delivery are both central to the model of service delivery defined by the UK's National Service Framework (NSF). The NSF, as we noted above, together with various updates, define current government policy on mental health in England and Wales. To the extent, therefore, that these NSF principles correspond directly with two key principles of VBP, respect for diversity is very far from the feared 'anything goes'.

A number of other VBP constraints on policy and practice are spelled out in the Framework. Some of these are negative. Thus, the final unnumbered paragraph in the top half of the Framework spells out that VBP is 'anti-discriminatory': racism, for example, is inconsistent with democratic respect for difference. Other constraints are positive. Being 'open and responsive to change' (bullet 4) is a direct reference to the 'open society' of VBP noted above. Again, VBP emphasizes *positive* self-regard (it is reflective', bullet 5), it is concerned with *positive* as well as negative values (it is 'balanced', bullet 6), and with *positive* working relationships supported by good communication skills (it is 'relational', bullet 7). VBP, then, in a word, is 'recovery' oriented: it builds on the 'strengths and resiliencies of *individual* users', recognizing that 'there are many *diverse* routes to recovery' (bullet 2, emphasis added).

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Implementation

VBP thus has a rich set of practical corollaries as identified in the Framework. But the Framework, coming now to the last question in Exercise 18, also gives a number of clear indications of how policy is to be converted into practical action. Some of these are implicit: the last three bullet points, specifying that VBP is reflective, balanced, and relational, cover attitudes that are essential to effective working where values conflict. The Framework, though, also makes explicit in its final unnumbered paragraph, that implementation will depend on future 'educational and research initiatives'.

VBP, then, is very far from a recipe for 'anything goes'. It has the potential, at least, to be practically effective. But what risks are there of taking VBP into policy and practice in mental health? What are the possible downsides?

Dangerous downsides

In piloting the Values Framework, many respondents joked about 'lists of worthy values that get stuck up on the wall in the Chief Executive's office and are then promptly forgotten'! The NIMHE Values Framework is not such a list. To the contrary, it is a framework for *action*. But could its very potency have downsides?

EXERCISE 19 (10 minutes)

Think about this question. What are the risks of having a 'National Framework of Values for Mental Health' that, far from being a list of aspirational values mouldering on the Chief Executive's wall, has the potential, in the final words of the Framework, to 'give effect to the principles of Values-Based Practice'?

In piloting the Values Framework, members of the Values Project Group received much positive support for the approach (also reflected in 'hits' on the 'connects' website noted above since publication).

Two equal and opposite dangers in implementation were identified, however. On the one side was the danger already noted, of the Framework remaining, like the all-too-familiar lists of values, merely aspirational. On the other side, though, was the danger of the Framework being used, not to free up the resources of diversity, but as a weapon that allows one group of stakeholders to impose their values on other stakeholders.

Avoiding these twin dangers, the equal and opposite dangers of ineffectiveness and of all-too-effective partisan take-overs, will depend on the training and research initiatives signalled in the last paragraph of the Framework. We describe recent training initiatives in VBP in the next section. We return to research in Chapter 21.

4) Values-Based Practice and clinical practice skills

The skills underpinning VBP cover four areas, defined by Principles 6–9 of VBP, awareness, knowledge, reasoning skills, and communication skills.

Training in ethics and in Values-Based Practice

The skill areas of VBP correspond broadly with the aims of ethics teaching in health care outlined in the first section of Chapter 17. There are differences, however, as we should expect, given that the overall aim of VBP is to add new tools to the values toolkit of health care.

Thus, 'change of attitudes', one of the aims of ethics teaching, does not appear as a training objective in VBP at all. This is because, unlike ethics, at least in the quasi-legal form in which it impacts on practice, VBP does not seek to prescribe 'right' attitudes to the development of which training should be directed (unless respect for difference, as the premiss of VBP, is considered an attitude). The remaining skills areas, although important in both kinds of training, are important in different ways and for different reasons. We will consider each of these briefly.

Principle 6 of Values-Based Practice: raising awareness

Raising awareness is the first skills area emphasized both in ethics training and in VBP. As an area that is fundamental to VBP, it has been the subject of an extensive process of development and piloting of training materials in what we believe is a unique joint programme, initiated by Matt Muijen, as Director of a major mental health NGO, The Sainsbury Centre for Mental Health (SCMH), and the Philosophy and Ethics of Mental Health (PEMH) programme at Warwick University. In the next exercise, we look at how this works out in practice.

EXERCISE 20

Box 18.3 gives an extract from a training workbook in VBP, including all four VBP skills areas, developed by the SCMH programme lead for VBP, Kim Woodbridge, and Bill Fulford (Woodbridge and Fulford, 2004). As you will see, this is an exercise that aims to raise awareness of values.

1. Can you identify the philosophical origin of the exercise?, and
2. How does this differ from a corresponding exercise in raising awareness in traditional ethics?

The workbook in VBP was developed and piloted by Woodbridge and Fulford with mental health professionals and users of services in such challenging areas as assertive outreach teams and crisis intervention. The objectives of the workbook could thus not be more practical. The exercise, though, is directly based on J.L. Austin's 'ordinary' language approach to philosophical method. Thus the reader is encouraged to review a piece of text drawn from practice—a letter, or care plan, etc.—and to focus, not on the message, but on the words actually used.

In Chapter 4, we adopted Austin's approach as a research method: it was one way of gaining clearer (or more complete) understanding of the meanings of concepts—illness, disease, mental illness, etc.—that are important in mental health. Here,

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Box 18.3 Activity 8: Raising awareness through language

Please read through the following extract, which is an example of the sort of text that can be found in many policy documents, and then answer the questions below:

This Trust is supporting the change and reconfiguration of services to best meet NSF and other guidance for both adult and older mental health service users. There are some common themes for services throughout the Trust. These include:

- Developing effective management structures to lead and support change.
- Developing organisational structures in each area to support clinical governance, risk management and health and safety requirements.
- Implementing financial structures to ensure balanced budgets.
- Establishing cross area development groups to take forward required service developments in adult, older people, child and adolescent, and drug and alcohol services.
- Ensuring services provide fully integrated health and social care teams.
- Providing single points of access to services to ensure effective referral pathways and to support the targeting of resources.
- Reconfiguring where required to organise adult services to support functional models, to target skills and resources against standard and enhanced CPA [Care Planning Approach] levels of care.
- Developing minimum standards for CPA.
- Progressing approaches to provide a workforce fit for purpose, concentrating on training, modernising roles and responsibilities and supporting staff at work (including compliance with NHS Plan 'Improving Working Lives' standards).
- Influencing workforce planning Trust-wide with direct access of senior Trust representatives into workforce planning decision making, where previously local services have been isolated and with little influence on the mental health agenda.
- Establishing joint commissioning approaches and reaffirming Local Implementation Teams as the key commissioning groups for each area.
- Progressing service developments and/or monitoring arrangements to maximise the repatriation of expensive out-of-area private placements and minimise the use of private sector services.
- An acceptance that resources currently available are significantly insufficient, but a key objective that services will be targeted and arranged to be as effective as possible within those limited resources.
- The argument for additional resources will be best made once services are configured, as far as possible, to match best-practice models, NSF and performance targets.
- Limited resources should mean the targeting of services and not the arrested development of skills, training, roles and supporting information technology systems.

Question 1

Underline any value judgements (for example: effective, limited, best).

Question 2

What values are apparent throughout the extract? What is seen as desired, important or a priority?'

Question 3

Whose are these overall values? What are the implications for the values identified? Do they conflict in any way?

Question 4

Are there any values missing or that you would like to be emphasized?

essentially the same approach is used as a training method: attention to language use highlights and allows trainees to recognize the values—some explicit, others implicit—shaping their practice. In pilot programmes this has proved highly effective with service providers in both voluntary and statutory sectors (Fulford *et al.*, 2002a; Woodbridge and Fulford, 2003).

The workbook in VBP (Woodbridge and Fulford, 2004) was launched by the Minister of State with responsibility for mental health, Rosie Winterton, at a conference in London in July 2004. In its own right, and as one of the two sources for a national training programme in generic skills for mental health and social care (the other source being EBP), the workbook will support a rollout of training in both voluntary and statutory sectors in the UK from 2005 (National Institute for Mental Health England, *et al.*, 2004), and there are similar initiatives in a number of other countries (Fulford *et al.*, 2004). This is clearly an area, then, in which analytic philosophy, far from being as its critics in the 1980s and 1990s suggested, practically impotent, is proving highly effective in some of the most challenging areas of mental health practice.

Many variations of this awareness raising theme have been developed by the SCMH/PEMH partnership. Their shared origin, though, is in the linguistic analytic methods pioneered by Austin. Correspondingly, therefore, their objectives are very different from the objectives of awareness raising methods in ethics. In ethics, dilemmas—difficult or contentious cases—are used to raise awareness of ethical issues: dramatic rather than everyday cases serve this purpose best; and there is often someone who has 'got it wrong' (failing to respect autonomy, for example–see,

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e.g. Kushner and Thomasma, 2001). In VBP, attention to language use helps to raise awareness of values generally; everyday rather than dramatic texts serve this purpose best; and the intention is to raise awareness as such, not to highlight 'good' and 'bad' values.

Principles 7–9 of Values-Based Practice

Similar contrasts can be drawn between VBP and ethics training for the remaining skills areas.

- *Increasing knowledge* (Principle 7) is of secondary importance, even somewhat suspect (Gillon, 1996), in ethics. Recently, there has been a growing recognition of the importance of basing ethical decision-making on fact not fancy (Widdershoven *et al.*, forthcoming). In VBP, any method for gaining knowledge of values, qualitative or quantitative, narrative, evidence-based, or whatever, is fundamental. It is fundamental theoretically because, as in Hare's analysis of value terms (Hare, 1952), the criteria for value judgements are descriptive (or factual) criteria. It is fundamental practically because our intuitions about other people's values are demonstrably unreliable (Fulford *et al.*, 2002b).
- *Reasoning skills* (Principle 8). Any of the methods of ethical reasoning described earlier in this chapter have a place equally in VBP as in traditional ethics. Their role is different, though. In ethics, reasoning skills are used to decide what is 'right'. In VBP their role is to help us explore the values likely to be operative in a given context. VBP is in this respect closer to theoretical bioethics than to the dominant quasi-legal regulatory approach of ethics in practice. In their original description of the use of principles in bioethics, Beauchamp and Childress (1989), as noted above, make clear that prima facie principles, as they call their four principles, should be used to open up our thinking about an ethical issue, not, as they have often been misrepresented, to generate answers.
- *Communication skills* (Principle 9) have an executive role in quasi-legal ethics but a substantive role in VBP. In quasi-legal ethics communication skills are used to explore a situation in order to decide what rules apply and then to help make the rules 'stick'! Their role is thus secondary. In VBP, by contrast, communications skills have a primary role. In VBP a 'good decision' is defined as much by 'how' as by 'what': that is to say, in VBP a good decision is defined as much by *how* the decision is arrived at, and *how* it is implemented, as by *what* decision is taken and *what* is actually done.

6) Values-Based Practice, Evidenced-Based Practice, and a new alliance between users and providers in health-care decision-making

The 10th principle of VBP, described in Box 18.1 as the 'who decides' principle, has the effect, as we will see, of building a new alliance in health-care decision-making.

Principle 10 of Values-Based Practice: 'who decides'

In shifting the 'locus of control' in health-care decision-making, Principle 10 of VBP marks a further and perhaps crucial difference between VBP and quasi-legal ethics. In quasi-legal ethics, it is ethicists, lawyers, members of ethics committees, and others external to the decision in question, who decide what ought to be done. Ethicists and lawyers write the rules: regulatory bodies interpret and enforce them. In VBP, by contrast, it is those directly concerned in a given decision who decide. VBP, in the words of Principle 10, 'puts decision-making back where it belongs, with users and providers' (and, we might add, with managers and policy makers) 'at the clinical coal-face'.

Principle 10 as a summary of Values-Based Practice

Principle 10 captures many of the important features of VBP understood as a new set of tools to support health-care decision-making, a set that extends, without displacing, the tools of quasi-legal ethics.

Thus, Principle 10, in transferring the locus of control in health-care decision-making from ethicists/lawyers to users/providers, also transfers responsibility. The buck, as they say, stops with the decision-maker. One consequence of this is the new and more substantive roles for the four areas of clinical skills defined by Principles 6–9, awareness, knowledge, reasoning skills, and communication skills.

The 'decision-maker' in VBP, however, is an alliance of user and provider. VBP is 'patient-centred', certainly (Principle 4); in a democracy of values, *health-care decisions*, to repeat the crucial phrase from the third R of the NIMHE Framework, should start from 'the values of each individual service user/client and their communities'. But VBP is premissed on *reciprocal* respect (the key word used in bullet point 2 of the NIMHE Framework). VBP, therefore besides being patient-centred, is also multidisciplinary (Principle 5).

This is not a matter, merely, as it might be even in quasi-legal ethics, of fairness. The different values represented by the many different professional and voluntary groups involved in multidisciplinary service provision, supply the 'balance of legitimately different values' (Principle 5 again), to which good process in VBP is directed, and on which effective health-care decision-making, whether about diagnostic assessment or treatment (Principle 1), whether explicitly value-laden or not (Principle 2), and whether in mental health or, increasingly, in other areas of health care (Principle 3), critically depends.

Principle 10 and the parallels between Values-Based Practice and Evidence-Based Practice

Principle 10 of VBP, if highlighting and drawing together some of the differences between VBP and quasi-legal ethics, also brings us back to the parallels between VBP and EBP. Again, we should not be surprised by the extent of these parallels, VBP being a product of the same philosophical value theory, that, in Part I (chapter 6), led to our 'full-field' fact + value model of the conceptual structure of medicine. Thus,

- *Principle 1* of VBP, the two-feet principle, directly corresponds with the equal and complementary roles of fact and value, or

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more exactly, description and evaluation, in the full-field theoretical model of Part I.

- *Principle 2* of VBP, the 'squeaky wheel' principle, applies equally to both sides: health-care decision-making has always been based jointly on facts and values; but we need EBP as we need VBP, nowadays, because of the growing complexity of both factual and evaluative sides of the decision-making equation.
- *Principle 3* of VBP, the 'science driven' principle, also applies to both sides: the growing complexity of health-care decision-making is driven by advances in science and technology, directly on the fact side, indirectly on the value side, i.e. as described above, by way of the extended choices in health care opened up by science and technology.

Principle 10 and the anti-parallels between Values-Based Practice and Evidence-Based Practice

The tools of VBP, of course, fashioned as they are to deal with different aspects of the growing complexity of health-care decision-making, are different from the tools of EBP. In EBP, as we saw in Part III, the focus is on information that is as *perspective-free* as possible. At the top of EBP's 'evidence hierarchy', then, are the results of meta-analyses of high quality research. The tools of such meta-analyses, statistical and IT-based, are designed to approximate to the traditional scientific ideal of what Thomas Nagel characterized as a 'view from nowhere' (Nagel, 1986). The outputs from EBP, correspondingly, the clinical practice guidelines that support health-care decision-making, are derived by consensual closure through progressive reduction of differences of view.

In VBP, by contrast, the need is for information that is as *close as possible* to the perspectives of those involved in a given decision. At the top of the 'values hierarchy' of VBP, then, is *perspectival* information about values. The tools of VBP, correspondingly, the tools to deliver perspectival information, are the practice skills defined by Principles 6–9 of VBP, combined with the models of service organization defined by Principle 4 (the Patient-Centred Principle) and Principle 5 (the Multidisciplinary Principle). Practice skills deliver high-quality information about values, which, combined with appropriate models of service organization, support what one of us has called elsewhere a 'dissensual' approach to health-care decision-making, i.e. an approach to health-care decision-making that is based, not on consensual closure through reduction of differences, but on an open balance of legitimately different value perspectives (Fulford, 1998).

Principle 10 and the interdependence of Values-Based Practice and Evidence-Based Practice

VBP and EBP, then, as we noted at the start of this section, being responses to different aspects of the growing complexity of health-care decision-making, are complementary. They are complementary in their parallels. They are complementary in their antiparallels. They are also, although presented here as distinct sets of decision-support tools, strongly interdependent. The tools of EBP, for example, are important in VBP under Principle 7, the 'knowledge' principle, in helping to supply high-quality generalizable evidence about values (Fulford *et al.*, 2002b). Similarly, the tools of VBP are the basis for a more balanced and positive approach to the 'ethics' of research and the role and functioning of research ethics committees (Dickenson and Fulford, 2000, chapter 10).

There are also deeper theoretical links between VBP and EBP. Value judgements, you will recall from Part I, are, in Hare's clear formulation, based on descriptive criteria: so, EBP, where relevant, will supply evidence about whether or not a given criterion is satisfied. Conversely, work in the philosophy of science, as we saw in Part III, has shown the extent to which epistemic and other values permeate all aspects of the scientific process, from observation, through the selection and design of research programmes, to the interpretation of results, and the adoption of theories. To the extent, therefore, that legitimately different values are in play, the tools of VBP have a potential role in science no less important than their role in health-care decision-making.

Principle 10 and a new user-provider alliance in health care

It is the complementary and interdependent natures of EBP and VBP which is the basis for a new alliance between users and providers in health-care decision-making. As noted in the last section, overuse of the tools of quasi-legal ethics has a number of downsides. Among the most serious of these has been a progressive alienation of users from providers of services. This is inevitable where ethics, as in its current dominantly quasi-legal interactions with practice, adopts the role primarily of guardian, 'protecting' users of services from what are portrayed as essentially predatory providers.

The justification for this approach is that providers sometimes deliberately exploit their positions of power to the disadvantage of users. It is a proper function of law and ethical regulation, therefore, as we noted above, to provide a framework of principles, procedures, and sanctions, aimed at protecting users from such betrayals of the central health care value of patient-centred practice.

Extend this proper 'framework' function of law, however, to the 'code inflation' of quasi-legal ethics, and the danger, faced equally by users as by providers of services, is of a wedge of mutual fear and resentment increasingly being driven between them. Principle 10 of VBP, in restoring the 'locus of control' to the users and providers involved in a particular decision, aims to reverse this process, replacing alienation with alliance. In this, surely most urgent of aims, VBP and EBP, as the final reading in this section makes clear, are indeed both complementary and interdependent.

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EXERCISE 21

Read the extract from the Introduction to a widely read and respected textbook on EBP:

> Sackett, D.L. Straus, S.E., Scott Richardson, W., Rosenberg, W., and Haynes, R.B. (2000). *Evidence-Based Medicine: how to practice and teach EBM*, (2nd edn). Edinburgh: Churchill Livingstone

Link with Reading 18.9 (on disk already)

- What model of health care is reflected in this definition of EBP?

EBP is widely thought to be concerned only with applying the results of research to practice. In this reading, however, Sackett *et al*. (2000) define evidence-based medicine as involving three key elements, best research evidence, clinical experience, and patients' values. There could surely be no clearer statement of the full-field, fact+value, model to which we came at the end of Part I, and from which, in this session, we have derived the principles of VBP.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What is Values-Based Practice?
2. Where does Values-Based Practice start from (what is its premiss)? And how does it differ from substantive ethics.
3. What three principles link Evidence-Based with Values-Based approaches to health-care decision-making?
4. What model of service delivery is required to support 'good process' in Values-Based Practice?
5. What particular clinical skills are required to support good process in Values-Based Practice? (We noted four.)
6. What is the aim of combining Values-Based with Evidence-Based approaches to decision-making in health care?

Conclusions: combining law and ethics with Values-Based Practice

Complementary tools in the toolkit

In this chapter we have considered a range of tools for working with values in mental health derived respectively from bioethics (principles, casuistry, and perspectives), general ethical theory (deontological and utilitarian), and analytic ethical theory (VBP).

Mental health, we have argued, requires a sharper set of tools because of the additional depth dimension of conceptual difficulty underlying ethical problems in this area, as outlined in Chapter 17. VBP, we have further argued, offers a set of tools for dealing with a particular aspect of this complexity, namely, the greater diversity of values in mental health compared with other areas of health care, particularly the high-tech areas on which bioethics, at least in the strongly regulative form it has taken in practice, has traditionally concentrated.

The relationship between regulative ethics, or quasi-legal ethics as we have called it, and VBP, understood as different sets of tools in the toolkit for working with values in health care, is shown diagrammatically in Figure 18.2.

In this figure regulative ethics is shown as being properly concerned with the 'framework' values that are widely shared for a given group. These shared framework values include, for current health-care practice, autonomy and beneficence, as discussed earlier in this chapter. Other shared values, as shown in the figure, include confidentiality and sharing of information, and acting in the patient's best interests. So understood, then, as being concerned with the values that (for a given group at a given period) are widely shared, quasi-legal ethics is

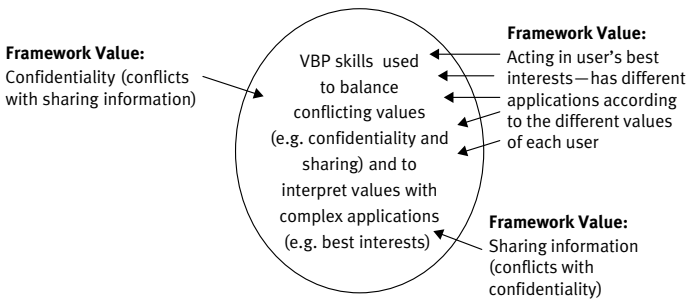

Fig. 18.2 The complementary relationship between quasi-legal ethics and Values-Based Practice.

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an extension of what the Oxford philosopher of law, H.L.A. Hart, described as the proper function of law itself, to provide a choosing framework (Hart, 1968).

Such a framework, of shared ethical values filling out health care law, is, as we have several times emphasized, essential for health-care decision-making that seeks to maximize choice. As the diagram in Figure 18.2 shows, however, there are two reasons why the framework of ethics and law cannot, in itself, be sufficient. First, framework values conflict: autonomy is in tension with beneficence, as Beauchamp and Childress (1989) argued; and confidentiality is in tension with the sharing of information (Fulford, 2001). Second, framework values have complex interpretations: 'best interests', for example, will mean very different things according to the often very different values of those concerned in a given decision.

It is where framework values conflict, then, and/or have complex interpretations, that the good process model of VBP complements and extends the tools of quasi-legal ethics. In the next chapter we turn to law itself, and to its role in supporting health-care decision-making especially in the values-complex environment of mental health. We return to VBP, and to its role particularly in relation to diagnosis, in chapter 21.

Useful websites

- http://www.basw.co.uk/articles.php?articleId=2&page=6 Values and principles of social work.
- http://www.doh.gov.uk/mentalhealth/implementationguide. htm For the extract on values underpinning the Mental Health National Service Framework.
- http://www.nice.org.uk National Institute for Clinical Excellence (NICE). Schizophrenia guidelines and other information.
- http://wwwnimhe.org.uk National Institute for Mental Health England. For information regarding implementation guides and mental health policy.
- http://www.nmc-uk.org Code of professional conduct for nursing and midwifery.
- http://www.rcpsych.ac.uk/publications/cr/council/cr83.pdf The duties of a doctor registered with the General Medical Council.
- http://www.scmh.org.uk For further useful information in general about practice and policy issues.
- http://www.scie.org.uk Social Care Institute for Excellence. For information regarding social models of care and other general social care information.
- http://www.warwick.ac.uk The University of Warwick.
- http://www2.warwick.ac.uk/fac/med Warwick Medical School.

Reading guide

Ethics and bioethics

Detailed reading guides on general ethical theory and on bioethics are given in chapter 2 of Dickenson and Fulford's (2000) *In Two Minds*. Among introductions to ethics, a modern classic is James Rachels' (2003) *The Elements of Moral Philosophy*. D.D. Raphael's (1994) *Moral Philosophy* includes a guide to further reading for both classic and modern sources. Mary Warnock's *Ethics since 1900* (1978) remains an exceptionally clear introduction to each of the main ethical theories noted in this chapter. R.M. Hare's (1997) *Sorting Out Ethics* offers a brief but authoritative introduction to each of the main philosophical theories of ethics. A clear summary of Kantian, consequentialist and virtue ethics, organized as an extended debate, is given in Marcia W. Baron, Philip Petit, and Michael Slote (1997) *Three Methods of Ethics*.

Mental health and mental illness are among the subjects covered in Michael Parker and Donna Dickenson's (2000) *The Cambridge Workbook in Medical Ethics*. *The Cambridge Workbook* also introduces new approaches beyond principlism and casuistry, particularly from the European tradition. Grant Gillett's (1989) *Reasonable Care* is an entertainingly written introduction drawing on much case material.

Principles

The classic of the principles approach is Tom Beauchamp and James Childress' (1989) *Principles of Biomedical Ethics*. Raanon Gillon's (1985) *Philosophical Medical Ethics* offers a brief and practically focused introduction to the principles approach. Gillon's edited collection on the principles approach, his *Principles of Health Care Ethics* (Gillon and Lloyd, 1994), includes Fulford and Hope's (1994) 'Psychiatric ethics: a bioethical ugly duckling', which discusses the strengths and limitations of the principles approach in psychiatry.

Casuistry

Al Jonsen (a theologian) and Stephen Toulmin (a philosopher) (1988) wrote their now classic book on casuistry *The Abuse of Casuistry* after serving on a Presidential Commission on Bioethics (see text).

Principles and casuistry are compared as approaches to ethical issues of consent in psychiatry in Fulford and Hope's (1994) chapter in Gillon and Lloyd's *Principles of Health Care Ethics*. Priscilla Alderson's (1990) *Choosing for Children* shows the value of qualitative research.

Perspectives

The Oxford psychiatrist and Professor of Medical Ethics, Tony Hope, was among the first to emphasize the importance of perspectives in ethical reasoning in medicine; see his *Medical*

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Ethics: a very short introduction (2004). Narrative ethics has recently come into prominence as part of narrative-based (in contrast to evidence-based) medicine: see Anne Hudson Jones' (1999) article, *Narrative in Medical ethics*, which was published as part of a series on narrative approaches to medicine in the *BMJ*. Carl Elliott's (1999) collection of essays, *A Philosophical Disease* illustrates the value of storytelling in biomedical ethics. The *Declaration of Madrid*, the first code to spell out the importance of the 'user' voice in clinical decision-making, was published by the World Psychiatric Association, Geneva (1996).

Professional ethics and the role of codes

Authoritative introductions to these two areas specifically for psychiatry are Allen Dyer's 'Psychiatry as a profession' and Sidney Bloch and Russell Porgiter's 'Codes of ethics in psychiatry' (chapters 5 and 6, respectively, of *Psychiatric Ethics*, Bloch, Chodoff, and Green, 1999). See also Ruth Chadwick's (1994) edited collection *Ethics and the Professions* for an excellent overview. The practical and theoretical links between ethical codes, concepts of disorder, and communication skills in psychiatric ethics, is described in Fulford and Bloch's (2000) chapter in the *New Oxford Textbook of Psychiatry*, on 'Codes, concepts and clinical practice skills'. Chapter 11, on 'Inter-professional relations', of the BMA's (1993) *Medical Ethics Today* is a helpful review of the ethical issues arising in multidisciplinary team working. The ethics of teamwork between professionals is also explored in Perkins and Repper (1998) *Dilemmas in Community Mental Health Practice*.

Psychiatric ethics

As noted in the text, the first edition of Sidney Bloch and Paul Chodoff's, *Psychiatric Ethics*, was one of the trail blazers for the otherwise relatively neglected area of psychiatric ethics (Bloch and Chodoff, 1981). The third edition (Bloch, Chodoff, and Green, 1999), together with complementary case studies and guides to further reading in its sister volume, Dickenson and Fulford's *In Two Minds*, includes chapters on each of the main areas of ethical concern in psychiatry as noted in this and other reading guides. Rem B. Edward's (1982) *Psychiatry and Ethics* is a valuable edited collection of classic articles. Also important among early publications were Michael Moore's (1984) *Law and Psychiatry: rethinking the relationships*, and Alan Stone's (1984) *Law, Psychiatry and Morality*. Early reviews defining the subject include those by Kopelman (1989), Hope (1990), and Anzia and Puma (1991). Potter's (2004) explores gender issues.

A number of both psychiatric and bioethics journals have included special issues on psychiatric ethics, for example (Fulford and Radden, 2002) 'Bioethics: Special Issue on psychiatric ethics'). The update journal, *Current Opinion in Psychiatry*, includes regular articles on ethical issues both in specific clinical topic areas and in the *History and Philosophy Section*.

Philosophy, Psychiatry, & Psychology publishes articles that explore the conceptual issues underpinning problems in psychiatric ethics: see, e.g. by Pat Bracken (1995) and Eric Mathews (1995) on Michel Foucault and critical psychiatry; Hinshelwood (1995) on personal identity (see also Part V), and on the ethics of psychotherapy (Hinshelwood, 1997a), with commentaries by Mace (1997), Sturdee (1997a), and Thornton (1997), and a detailed response (Hinshelwood, 1997b; also Hinshelwood, 1997c). *Philosophy, Psychiatry, & Psychology* has had a special issue on suicide and psychiatric euthanasia (1998; volume 5/2).

Other topics explored have included Dickenson and Jones (1995) on developmental issues (in their 'True wishes: the philosophy and developmental psychology of children's informed consent'), with commentaries by Eekelar (1995), McCormick (1995), Murray (1995), Parker (1995), and Wells (1995); Stocker's (1997) 'Aristotelian akrasia and psychoanalytic regression', with a commentary by Sturdee (1997b); Putnam (1997) on 'Psychological courage' with a commentary by Moore (1997); Gillett (1998a) on 'Relativism and the social constructivist paradigm' with commentaries by Fourcher (1998) and Phillips (1998), and a response by Gillett (1998b); on feminism, Burman's (2001) 'Feminist contributions' to reframing current controversies around memory, Potter's (2001) 'Feminism', and Richmond's (2001a) 'Psychoanalysis and feminism: anorexia, the social world, and the internal world', with commentaries by Adshead, 2001, Mitchell (2001) and Hinshelwood (2001), and responses by Burman, (2001b) and Richmond (2001b); on race, Nissim-Sabat's (2001) 'Psychiatry, psychoanalysis and race'; and on power relations, Lilleleht's (2002a) 'Progress and power: exploring the disciplinary connections between moral treatment and psychiatric rehabilitation' with commentaries by Charland (2002) and Bracken (2002), and a response by Lilleleht (2002b).

The particular problems raised by psychiatric research ethics are discussed in Fulford and Howse (1993) 'Ethics of research with psychiatric patients: principles, problems and the primary responsibilities of researchers'. Chapter 10 of *In Two Minds* gives a worked case example of psychiatric research ethics.

Values-based practice: (1) The theory

The theory and skills base of VBP are set out in Fulford's (2004) chapter in Radden's *Companion*. The chapter includes a case history done as a series of vignettes illustrating how each of the 10 principles work out in the story of a particular person, Diane Abbot, an artist who found she could not 'see colours'. Holmes and Lindley's (1989) *The Values of Psychotherapy*, and Marina's (1999) 'The problem of values in psychiatry', set out the issues from which VBP starts; and Perkins (2001) and Campbell (2002) make explicit the service user perspective. As described in the text, VBP is derived from philosophical value theory as in the work particularly of Hare (1952), Geoffrey Warnock (1971), and others

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in the Oxford analytic tradition, applied to health-care contexts in Fulford (1989, *Moral Theory and Medical Practice*), and combined with substantive work on value diversity using both analytic methods, notably Sadler (2002, *Descriptions & Prescriptions: values, mental disorders, and the DSMs*), phenomenology, notably Stanghellini (2004, *Deanimated Bodies and Disembodied Spirits*), and empirical research, notably Colombo (1997, *Understanding Mentally Disordered Offenders: a multi-agency perspective*), Colombo *et al.* (2003, 'Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams'), and Tan *et al.* (2003, 'Anorexia nervosa and personal identity: The accounts of patients and their parents').

The theory of VBP is further developed in relation to:

1. Child and adolescent mental health services, in Fulford and Williams (2003) 'Values-based child and adolescent mental health services?'. This is a review article setting VBP in a policy context for the UK and illustrating each of the ten principles with examples from child and adolescent mental health.
2. The relationship between clinicians and managers, in Fulford and Bennington's (2005) 'VBM^2: A collaborative values-based model of health care decision making combining medical and management perspectives' (in Williams (ed.) *Medical and Management Perspectives in Child and Adolescent Psychiatry*). This article illustrates the resources of VBP for bringing together medical (K.W.M.F.) and management (J.B.) perspectives. The VBM^2 of the title captures the idea that differences of values, which are a 'problem' to be solved in traditional quasi-legal ethics, become a positive resource for health-care decision-making in VBP.

In a discussion of Colombo and Fulford's work on models of disorder (see Part I) in *Philosophy, Psychiatry, & Psychology*, Bendelow (2004), Williams (2004), Williamson (2004), and Heginbotham (2004), provide important critiques of developments in VBP, respectively from the perspectives of the social sciences, for professional training and regulation, for multiagency organization of services, and for policies that are capable of delivering genuinely user-centred care.

Articles on aspects of ethics and value theory relevant to different areas of psychopathology have been published in *Philosophy, Psychiatry, & Psychology*, for example: (1) Moore *et al.*'s (1994) 'Mild mania and well-being', with commentaries by Nordenfelt (1994) and Seedhouse (1994); (2) Potter's (1996) article on false memory syndrome ('Loopholes, gaps, and what is held fast: democratic epistemology and claims to recovered memories'), with a commentary by Code (1996); (3) Mitchell's (1998a) 'Neurosis and the historic quest for security: a social-role analysis', with a commentary by Schwartz and Wiggins (1998) and a response by Mitchell (1998b); (4) Ward's (2002a) article on the nature of evil, 'Explaining evil behavior: using Kant and M. Scott Peck to solve the puzzle of understanding the moral psychology of evil people', with commentaries by Sverdlik (2002), Adshead (2002), and Mullen (2002), and a response by Ward (2002b); (5) on depression, Radden's (2003a) 'Is this Dame Melancholy? Equating today's depression and past melancholia', with commentaries by Brendel (2003) and Hansen (2003), and a response (Radden, 2003b); and (6) Clegg and Lansdall-Welfare (2003a), on 'Death, disability and dogma', with commentaries by Colman (2003), Casenave (2003), and Reinders (2003), and a response by Clegg and Lansdall-Welfare (2003b).

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