

FACT AND VALUE IN BIOETHICS: HOW TO GET RID OF THE DICHOTOMY*

Fact and value in bioethics: How to get rid of the dichotomy

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RESUMEN

Este artículo ofrece una perspectiva sobre el desarrollo reciente de la bioética, un campo en el que es habitual distinguir entre hechos y valores. Examinando cómo se usa la palabra “valor” en la ética biomédica más extendida internacionalmente, se muestra que algunos usos refuerzan cierta tendencia esencialista a tratar los valores como si fueran entidades independientes. Como ilustración y explicación de la creciente importancia de este fenómeno, describimos el “lenguaje de los valores” en la obra reciente de Diego Gracia, mostrando cómo su propuesta metodológica para la bioética emplea la dicotomía entre hechos y valores, y analizándola en relación con la de George Khushf para articular el debate sobre los conceptos de salud y enfermedad. Concluimos sugiriendo una manera alternativa de concebir los valores que permita superar esa dicotomía.

Palabras clave: hecho, valor, ética biomédica, normativismo, naturalismo.

ABSTRACT

This article offers a perspective on recent developments in bioethics, a field in which the distinction between fact and value is pervasive. By surveying how the word “value” is used in principle-based, mainstream biomedical ethics, it is shown that some uses enforce an essentialist tendency to speak of values as free-standing entities. As an illustration and explanation of the increasing pervasiveness of this language, both in English-speaking and

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Spanish-speaking bioethics, we describe the role of “value talk” in recent writings by Diego Gracia. We focus on how his proposal of a methodology for bioethics uses the fact/value dichotomy, and analyse his position in relation to the agenda for the debate on the concepts of health and disease proposed by George Khushf. As a conclusion, we suggest an alternative way of thinking about values in order to overcome the dichotomy.

Keywords: fact, value, biomedical ethics, normativism, naturalism.

1. Introduction

Despite V. R. Potter’s original coinage of the term “bioethics” in 1970 to refer to a bridge between science and the humanities, today it is often understood to relate to some version of biomedical ethics—most commonly, that of T. Beauchamp and J. Childress’s *Principles of Biomedical Ethics* (fifth edition, 2001). Potter came to define bioethics as “a global integration of biology and values”, “designed to guide human survival” (Whitehouse, 2003). This definition seems to rely upon an unrealistic vision of pre-1970s biology as a “value free” science, to which values had to be somehow added for the benefit of humankind. But this vision—rooted perhaps in the idea that physics should be a model for the rest of science—is not a good basis for present or past biology, or any other science directly dealing with human lives, as it has become agreed that “values enter into the process of science long before decisions are made about technical applications of scientific knowledge” (Dupré, 1993, 245). Thus some authors argue that we have entered a postmodern era, in which the robust role played by values in framing accounts of medicine is recognized (Veatch, 2006; Engelhardt, Garrett & Jotterand, 2006, 566). However, it is still held that bioethics brings the “language of values and disvalues” (Gracia, 1995, 205) to a mainly factual, “evidence-based” medicine.

In this paper we analyze the meaning, justification and role of “value talk” in bioethics, particularly in relation to principle-based accounts. We proceed by surveying how the word “value” is used by Beauchamp and Childress in their classical book, and argue that some of those uses are more problematic than others. We are skeptical of the essentialist tendency to speak of values as entities, as if they could exist outside actual processes of evaluation. As an illustration and explanation of the increasing pervasiveness of this language, both in English-speaking and Spanish-speaking bioethics, we describe the role of value talk in recent writings by Diego Gracia, arguably the most influential philosopher of medicine in Spain. We focus on his proposal of a methodology for moral deliberation, and describe his position in relation to the normativism proposed by George Khushf. As a conclusion, we advocate a stronger normativist

position, one that rejects the fact/value dichotomy. The factual and the evaluative—the medical and the non-medical, the old and the new—are not separated in bioethics, nor should they be.

2. Value talk in bioethics

The index to Beauchamp and Childress's *Principles* does not include an entry for the word "value". However, the word is used in that book in at least four different ways:

1. *The value of events, attitudes, actions*, and so on. Here we find expressions such as "the value of protecting autonomy" (99), the "value of moral integrity" (35), or the 'value of privacy' (296). In general, models and theories in bioethics put different value on different things (62); value is attached to the 'occurrence or prevention' of certain events (195), and this value can be therapeutic or not (352).
2. *The value of a person or human life*. Beauchamp and Childress write of "the patient's value for society" (127), "the value of the life for the person who must live it" (103), and "the value of that patient's life for others" (137). Human lives can have "social value" and even "economic value" (207). There could even be "lives with no value" (145).
3. *Personal, group, and societal values*. Here we find expressions such as "a particular person's choices or values" (66), "the patient's views and values" (100), or "the entrenched values and goals of medical professionals" (82). Values are not only held by individuals, as Beauchamp and Childress also write of "the values of the general public", "the values of people who have or have had a particular disease" (213), and "the shared values of a group" (233).
4. *Values embedded in judgments, assessments, and treatments*. Finally, Beauchamp and Childress argue that a key concept such as that of "medically indicated treatments" presupposes values (139); that risk-benefit analysis and other adjudication methods are not "value-free" (206), and that their resolution will depend on the "value judgments" of the decision makers. At bottom, they say, bioethical debates are often debates about goals, "and disputes about appropriate goals involve conflicts of values" (193).

This classification can be reduced to a simpler one, in which groups 1 and 2 are about values in the *possessive* sense of the word, while values in the groups 3 and 4 are understood in an *entitative* sense. In the first sense, value indicates a certain property or relation of something (be it an event, attitude, goal, person,

etc.). According to this use, value is “attached to” something: something *has* value. This is the traditional, economic, and possessive meaning of “value”. In the second sense, when Beauchamp and Childress write of the values of a given human group (patients, healthcare professionals, or society at large), or that something *is* a value, they are using a relatively new (appeared only 130 years ago), philosophical, and entitative meaning of the term, the one we use in phrases like “justice is a value”, “science should be value-free”, or “religious values are important” (Menéndez Viso, 2005).

Groups 1 and 2, then, are about values in the possessive or relational sense of the word (“X has value”), while “value” in 3 and 4 is used in the entitative or free-standing sense (“X is a value”). The distinction between these uses of the word is relevant to bioethics because of at least the following considerations.

When we say that something *is* a value, further arguments are often reduced to discussing whether that is or is not the case. But when we say that something *has* value, a plurality of arguments emerge, expressing the different relations that the thing in question might have with the other things that is compared to in order to ascertain its value. For instance, when Beauchamp and Childress discuss the “best interests standard” (103), they make a distinction between the value of a person’s life for herself vis-à-vis the value of her life for other persons.

When we talk of values as entities, it is easy to be essentialist, and think of them as Platonic ideas. As John Dupré puts it, “the existence of such real essences would imply that there is some unique, privileged scheme of classification, which assigns everything to a class defined by common possession of the appropriate essence” (1993, 60). If health *is* a value—even if “not our only value or goal”, as Beauchamp and Childress write (251)—then it seems as if it was always the same kind of thing, as if we already knew what it really is. But if we begin by saying that health (or different conceptions of health, because there are many and diverse) *has* value, it follows that it will have different value to different people.

When talking about values in the entitative sense, questions about hierarchy appear. If care is a value and so is dignity then sometimes it is impossible to realize one without neglecting the other, and the discussion revolves around which value will have priority, which one is the *real* value that one has to maximize (as in Beauchamp and Childress’ extreme reification of “value” in their discussion of utilitarianism, 341-348). But if we think that care has a value and that so has dignity, those values could fluctuate without having to presuppose that care or dignity should override one another. This way we would not construe the problematic cases as a “conflict of values”, but rather as a complex process of different evaluations over time.

In short, we favor possessive uses over entitative ones because the former do not commit us to any given hierarchy of values. As with any other ontology, a given axiological hierarchy can always be disrupted by the promiscuous real-

ity of human values, and ensuing discussions tend to make little headway. To speak of values in the possessive sense does not presuppose a fixed axiological and ontological order, and arguments can get started without prior agreement on what values are at stake, or on what values are at all.

3. An example: conflict of values in Spain

The Spanish film *The Sea Inside* (*Mar adentro*) won the 2005 Oscar Award for best foreign film. Directed and co-written by Alejandro Amenábar, *The Sea Inside* is based on the real life case of Ramón Sampedro, a former sailor who broke his neck and spent more than 25 years as a quadriplegic. On several occasions the Spanish courts denied his claims for the legalization of assisted suicide, and he died on January 12, 1998, by sipping a solution of cyanide through a straw (Guerra, 1999). In a scene of this film there is a heated argument with a catholic priest, Father Francisco, who argues that “life-denying freedom is not freedom”. To this, Ramón answers that “a life without freedom is not a life either”.

This is clearly not the best way to discuss topics in bioethics. In general, human beings value life and liberty, and we can say (in the entitative sense) that life and freedom are human values. However, if we frame Ramón’s case in the terms represented in the quoted piece of dialogue, as a conflict of incommensurable or mutually exclusive values (life and freedom, in this case), there is no way of advancing the discussion further. This is exactly what happens in the film: the argument between Ramón and Father Francisco ends without mutual understanding, and Ramón gives up hope in finding a solution to his problem through public discussion.

However, the possessive or relational use makes the situation clearer. Ramón’s life has a value for him, but not enough, because he also values freedom, and he considers himself to be a prisoner in his own body. Father Francisco values freedom, too (he is also a quadriplegic, but uses a state-of-the-art wheelchair with the help of a couple of personal assistants), but for him human life has a higher value.

This might sound obvious, but nevertheless provides a way out of the cul-de-sac in the argument between Ramón and Father Francisco. When someone says that Ramón’s life *has* a value, he or she is not simply describing his life, but measuring it by a scale, comparing it with other instances of human life. It is easy to realize that this value might change over time, depending on the terms of comparison (Menéndez Viso, 2005, 181-182). Thus pluralism is introduced, something that was absent in the dilemma “life without freedom” vs. “freedom without life”, in which the (impossible) task was to find out which one of the two *was* the real value that had to prevail.

Still, the entitative use is prevalent today. For instance, “value talk” is increasingly fashionable in Spanish bioethics, as can be seen in the methodology of biomedical ethics proposed by Diego Gracia, which we will examine now.

Ten years after Beauchamp and Childress published the first edition of their *Principles*, Gracia published his own *Fundamentos de bioética* (1989), a book that brought the four principles approach to Spanish bioethics. He is considered a paradigm case of the “peripheral bioethicist”, and has played a decisive part in the introduction and diffusion of contemporary bioethics in Spain and Latin America (Garrafa, Diniz & Guilhem, 1999).

The key concept of Gracia’s bioethics is that of deliberation, which he identifies with a step-by-step procedure that “must go through certain established stages”. In order to deliberate on the morally most appropriate course of action, Gracia (2003, 230-232) proposes a methodology based on the following stages:

1. Check the compliance of the course of action with moral principles.
 - a. Analyze the bioethical principles involved in the case.
 - b. Identify conflicts between values or principles.
2. Evaluate the likely consequences.
 - a. Evaluate the circumstances of a particular case and the likely consequences of the decision.
 - b. Determine if an exception to the principles may and should be made.

Gracia’s method thus requires identifying the values in conflict with bioethical principles or with other values (for Gracia, the principles of bioethics are human values important for the medical profession, but not the only ones; the process of deliberation might take into account non-medical values such as religious beliefs, etc., which might conflict with each other). In other words, his proposal of deliberation first “determines the values at stake” and then “analyzes possible courses of action according to their ability to realize the identified values, to finally look at the likely consequences” (Rodríguez del Pozo & Fins, 2006, 234).

In 1999, Gracia thought that ethics could be expressed in different, complementary, languages, including the language of principles and consequences, the language of virtues and excellence, the language of rights and duties, and the language of values and disvalues. Because he described the basic morality of “Latin cultures” as a version of virtue ethics, Gracia thought that a principlistic approach could be of most help in avoiding some “traditional defects” in those cultures, “like paternalism, lack of respect for the law and lack of tolerance” (1995, 205).

Of course, there are other reasons than those in order to favour a principle-based approach to bioethics. Because values could be too vague, and rules too specific, Beauchamp and Childress chose a language of principles in order to mediate between general values and particular rules. Both principles and rules are “general norms that guide actions”, but rules are more specific in content

and more restricted in scope, while principles “leave considerable room for judgment in many cases”. The language of principles steers a middle way, expressing “the general values underlying rules in the common morality” (12-13) and thus providing reasons in order to justify a course of action.

Principles provide reasons for action according to rules and values. Despite its critics, principles-oriented bioethics remains, “the most widely used account in biomedical ethics” (Gert, Culver & Clouser, 2006, 99), the “dominant paradigm” and “true bioethical orthodoxy” (Gracia, 1995, 194). Furthermore, principles are meant to be limited in number and reasonably consistent with each other, being hierarchical or at least capable of informing systems of thought in congruent ways. In contrast, values are haphazard, incongruent, and numerous (Shiffrin, 2006, 194). So why, in that case, is there a need to re-introduce values in the methodology of bioethics?

The first answer is general: values connote pluralism and difference in a way that principles cannot, and a constellation of values seems to provide a better description of contemporary moral life than a set of congruent principles. As Martha Nussbaum puts it, “the valuable things are plural, and are not reducible to some one valuable thing of which all other goods are mere functions”. This strongly suggests the possibility of insoluble conflicts of value, for it might be difficult or even impossible to pursue the entire set of valuable things to which a moral agent is committed (Nussbaum, 2001, xxix).

A second answer is more local. The Spanish healthcare ethos is becoming more and more pluralist—as is apparent from the way in which contemporary Spanish film portrays bioethical issues. It is not that, by character or national idiosyncrasy, “Latin people are profoundly uncomfortable with rights and principles” (Gracia, 1995, 205). What might be happening, rather, is that in a pluralist scenario, values, unlike principles, allow “freedom from theory-guilt”. Emphasis on principles implies a need for abstract elegance or symmetry. Emphasis on values, on the other hand, allows us to find “meaning in stories that cannot be categorized in systems” (Shiffrin, 2006, 194). In such a pluralist, post-modern scenario, theory loses ground to narrative.

Finally, this pervasiveness of value talk is not restricted to the Spanish-speaking bioethics community. Leading international journals in the field review books focusing on the values underlying decision-making processes, hailing them as examples of “how ‘value talk’ can be productive and effective” (Ravitsky, 2006). And the *UNESCO Universal Declaration on Bioethics and Human Rights* quotes many and diverse values, but does not provide a ranking method, something that can lead “to quite honest and potentially serious disagreements” (Häyry & Takala, 2005, 232).

4. Facts and values in medicine

In general, this engagement of medicine with values that is often associated with bioethics might be due to the role which health and illness play in the West. Max Weber and other sociologists have argued that medicine plays a special

role in the shaping of social values because civilizations are organized around a “soteriological vision”—an understanding of the nature of suffering, and the means of transforming it in order to achieve salvation or health (López, 2004, 877).

Whatever is meant by such vague expressions as “our values”, medicine is often at the core of them, and they are inextricably linked with concepts of health and disease. In particular, critics of Beauchamp and Childress have noted that the concept of disease is “the central concept of medicine and yet, at its core, it involves values, though what values and to what extent they play a role in defining the concept constitutes much of the debate in the literature” (Gert, Culver & Clouser, 2006, 129).

Because evaluative language provides reasons for action, science can hardly dispense with it. Thus the assumption of a sharp fact/value distinction or dichotomy is not only untenable but also often harmful. In large areas of science, the attempt to separate the factual from the normative is futile (Dupré, 2007, 30-31). Is this the case in medicine and health care? Again, we will use Gracia’s philosophy of medicine as an illustration.

Following a distinction made by Loren Graham (1981), Gracia (1991) distinguishes between restrictionist and expansionist views on this issue. Restrictionists see science as autonomous and separated from values; expansionists argue that science has unavoidable implications for values and vice versa, and this is the view that Graham and Gracia judge most reasonable, but one not without risks of nonmedical values intruding harmfully into medicine. Therefore, Gracia (1991, 66) argues for a “critical expansionism” in which philosophy must play a role in medical education so that values can be adequately assessed and medicine protected.

The development of Gracia’s bioethics fits well into George Khushf’s mapping of the agenda for the debate on the concepts of health and disease. These concepts function in the philosophy of medicine somewhat like demarcation criteria in the philosophy of science: they mark off the jurisdiction of medical science. According to Khushf (2007), this debate is crucial to any response to the current developments in health care, and should be framed philosophically as one between weak and strong normativists. Weak normativists see values as integral to health concepts, but share with naturalists “a confidence in our ability to tease out facts from values” (2007, 24). Strong normativists are skeptical of the demarcation project, think that facts and values cannot be disentangled, and hold that socioeconomic conditions unavoidably influence how pathology is understood.

We have just seen how Gracia’s methodology presupposes a distinction between facts and values. Actually, his procedure must start with “a detailed study of the clinical facts”, because the clearer these are the more accurate the identification of value conflicts that will result (Gracia, 2003, 230). There is a time for discussing the “clinical aspects of the medical record” (that is, for

setting the facts straight), and a time for determining the “values in conflict” with other values or principles. In this limited sense, his methodology shares one of the features of the naturalist position described by Khushf. However, he does not believe in a sharp fact/value dichotomy, but thinks that philosophy and history can help in distinguishing medical values from those that are nonmedical (Gracia, 1991, 68-69).

Because he sees values as integral to health concepts, Gracia is best described as a normativist. In his latest book, *Como arqueros al blanco* (2004), he argues that bioethics and its focus on patient autonomy introduce “a new human right”: the individual right to define health and disease. He sees the increasing importance of patient autonomy in the concepts of health and disease (that is, the increasing importance of their subjective aspects) as an irreversible phenomenon in Western societies. Because this process of “emancipation” is inevitable, Gracia says, “society must be educated in the normative or axiological dimension of health” (2004, 84-85). Otherwise, the introduction into clinical practice of the patients’ own definition of health and disease will carry arbitrary and harmful consequences.

Gracia is not a social constructivist. He writes that “values are supported by facts” (2003, 230), not the other way around, and tries hard to steer a middle way between the value-free positivistic illusion and the “science as politics” position. It is difficult to decide whether his position is a strong normativist one, in the sense favoured by Khushf. Let us recall that Gracia’s methodology is based on a hierarchical ordering of the four principles into two levels, where compliance with the principles of nonmaleficence and justice belongs to the public or “minimalist” ethics, and the principles of autonomy and beneficence belong to the “maximalist” or private realm. It could be argued that this distinction between the public and the private levels depends upon a previous distinction between two concepts of health, one more naturalist and the other more normativist. The first concept is used when appeals to nonmaleficence are made, as they usually rely on an objective, descriptive, more value-free concept of health (identified with “biological life” by Gracia, 2003, 231). The second concept is used when appeals are made to the principle of beneficence, which works with a subjective, normative, more value-laden concept of health (“beliefs or life ideals”). If this is correct, Gracia works both with a naturalist and a normativist concept of health, which makes his position difficult to describe. But nonmaleficence and justice are, in Gracia’s work, ultimately defined by a public deliberation process between all members of society. His position is therefore a normativist one, even though it does not fully fit in the “strong” variety description.

Using his work as representative of mainstream bioethics in Spain and Latin America, it could be said that Gracia’s theory favors a fact/value distinction without a dichotomy, and a normativist concept of health without loss of confidence in the classical distinction between the clinical and the socioeconomic

aspects of health care. It would be interesting to see how Spanish speaking bioethics faces the global challenges to the practice of health care identified by Khushf (2007), such as the overlap between administrators and clinicians, or the shift of focus to systems-based interventions. To this task we turn now.

5. Rejecting the dichotomy

In a famous expression, the surgeon René Leriche stated that “health is life lived in the silence of the organs” (Canguilhem, 1979, 180); that is, we are healthy as long as we live unaware of our body; once there is something wrong with an organ, it begins to act up, it breaks the bodily silence and we begin to experiment ourselves as ill or sick. This classical idea of health, one that can be traced back to Kant and Descartes, has been rejected in the 20th century, as the debate in philosophy of medicine over the concepts of health and disease becomes a discussion about the proper role of values in medicine and bioethics.

254 Although the contemporary debate started with an article published in the journal *Philosophy of Science* (King, 1954), the most widely discussed contribution is that by Boorse (1975), who argued for a purely descriptive definition of health as the “natural” functioning of all the sub-systems of an organism, which will correspond to statistically normal functioning in a suitable reference class. Many authors have criticized Boorse’s naturalism and its alleged axiological neutrality: some emphasize the instrumental character of clinical diagnosis, prognosis and treatment (Engelhardt, 1996), while others defend the intrinsically cultural and political character of disease classification, taking the early work of Foucault (1961) as an example. In general, these normativist critics argue that the concepts of health and disease are not value-free.

In this debate, and for reasons explained above, Gracia could be placed as a normativist. Khushf defends a strong version of this position, one in which “medical theories depend on individual and social conventions and decisions regarding what we want to treat and how we want to treat it, as well as on the resources we have for supporting our health systems” (2007, 24). According to Khushf, strong normativists do not think it possible to disentangle factual and evaluative judgments, but he nevertheless sees the fact/value dichotomy as manifest in traditional medical science, ethics, and policy. He aptly identifies the dichotomy at work in two of the most prominent structural features of contemporary medicine: the division of labor between administrators and clinicians, and the role of patient autonomy in health care relationships. In both cases he warns that we are facing a revolution in health care, in which medicine is being transformed because of socio-economic factors and in which, as a result, the fact/value dichotomy becomes increasingly blurred.

Khushf outlines an agenda for this debate “over the very soul of medicine” (2007, 26). We would like to continue it by arguing that his normativism can be even made stronger if we avoid free-standing (entitative) uses of “value” in favor of a more relational approach. After all, if the fact/value dichotomy is so

pervasive in traditional medicine, would it be good to rely on it in order to map the new realities of health care? As illustrated above, entitative uses of “value” are common in mainstream and peripheral bioethics, and instrumental in creating this dichotomy, which is generally used but philosophically problematic.

Even though our strategy is different, we share the overall aim of Khushf’s agenda. We do not reject the idea that values are integral to the meaning of pathology, or that medical standards of care should be open to a broader communal deliberative process. There might be legitimate uses of “value talk” in the writings of Gracia, and of Beauchamp and Childress, especially when they seek to show how diverse cultural, sociopolitical, and economic processes configure our health concepts. What we will seek to show is that the fact/value dichotomy becomes almost meaningless once we reject some uses of entitative “value”—that some underlying structures that are often taken for granted can indeed be made explicit, but without recourse to a misleading dichotomy.

Our discussion can be organized around three different areas of debate, namely: the division of labour between “clinical practitioners” and “administrators” of health care; the methodology of bioethical deliberation; and the distinction between medical and non-medical values, with the related question about the survival of the “older medical values” in our present context.

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6. Fact/value and the administrative/clinical division

We agree with Khushf that the traditionally deep “division of labor” between those who establish the conditions (the administrators) and those who engage in the practice (the physicians) will become increasingly blurred in the new context of health care. As he points out, administrators legitimately play a role in addressing health care quality, and often work with assumptions very similar to those of physicians (2007, 21).

However, we also think that this division only provides a material embodiment of the fact/value distinction inasmuch as “value” is understood in the entitative sense. If we used the word in the older, possessive, sense, it would be apparent that the main activity of health care professionals (or any other profession) is precisely that of valuing.

As an illustration, let us look at a process that, according to the traditional fact/value distinction, is thought to be strictly factual: a blood analysis. A complete blood cell count, one of the most commonly performed blood tests, measures red blood cells, white blood cells and platelets. What the test gives us is a list of numeric values, along with judgments about whether those “values” are *normal* or whether they indicate a given condition. Thus in ordinary health care interactions bodily damage is assessed; the therapeutic value of several treatments is ascertained; different factors such as diet, lifestyle, or genetic makeup, are evaluated in terms of their impact on the patient’s condition, and so on and so forth. When they perform these actions, professionals are valuing—values are the result and the means of their work.

The relevant distinction is not, therefore, between facts and values, but between precise, conclusive, or non-controversially established values (i.e., “facts”), and dubious, open or controversial ones. And by “values” here we do not mean Platonic ideas, essences, or the kind of things that are understood as such in the entitative sense, but rather the kind of results that we achieve by processes of measurement or comparison. Thus every health care professional, the administrator as well as the clinician, is valuing different things all the time (including disputed and undisputed facts, of course). Seen this way, there seems to be no need for the fact/value dichotomy as an epistemological foundation for medicine.

7. Moral methodology in the clinical context

Khushf correctly identifies the “current bioethical consensus” regarding the way patient values are to be integrated into medical decision-making. As we have seen in Gracia’s method, first the “clinical facts” are gathered; as he puts it, “[a] good medical record is always the basis of a good clinical round, and also of an ethical round” (2003, 230). As potential decision trees emerge (another step in Gracia’s method), the physician interacts with the patient to solicit her values, so that every course of action can be checked against them (as well as against its likely consequences, and against the principles of bioethics). Eventually, a decision is taken in accordance with this approach to moral deliberation.

Thus described, this deliberation process relies too much on “values” in the entitative sense. If we look at it without recourse to such entities, a different picture appears, one in which the ascertaining of facts is not previous or external to the deliberation of the best course of action. In this alternative picture, the relevant values (including “facts” such as test results, treatment survival rates, patient preferences, etc.) appear in the context of the decision making process—in the very course of deliberation, not before it. Understood in the possessive sense, values are never previous to the actual process of moral deliberation; rather, they are created, revised and modified throughout it. Even those values that are usually (entitatively) called “human values”, such as “life, liberty, and the pursuit of happiness”, are only manifest to us when we engage in the moral question about what to do now, in a particular situation in real time, often by means of conversations with family, friends, or health care professionals (Árnason, 1994).

The old image of health as “life lived in the silence of the organs” retains an element of truth: when we are healthy, we hardly notice it, either as a fact or as a value; as if health was invisible or silent until the very moment we get ill, or someone close to us does. The value of health is often (and painfully) only manifest to those who are already engaged in a clinical relationship. In these cases, people do not usually go to the clinic with a ready-made, ordered list of preferences; quite the opposite, such an ordering is often the patient’s work in progress.

In his book *The Lonely Patient* (2007), Michael Stein provides a graphic illustration of how convoluted and tortuous this decision-making process can be. After all, the concept of disease is not a simple one. Some authors have described it as a triad comprising “disease”, “illness”, and “sickness”, these terms reflecting professional, personal, and social perspectives that concern biological, phenomenological, and behavioral phenomena respectively (Hoffman, 2002). Stein’s essays speak of the concept of disease as perceived by the ill person, the subjective experience of the individual patient. Modern medicine has sometimes forgotten this concept of “illness”, focusing instead in the professional perspective of “disease”, while postmodernist criticism has often focused on “sickness” (as when Foucault challenged the modern use of the terms “mad” and “mentally ill” as synonyms).

Only after the 1970s, with the rise of bioethics and the patient’s rights movements, has the critique of modern medicine been directed at its ignorance of the patient’s own conception of health. The work of Arthur Frank and others has thus given rise to a sort of “narrative bioethics”, which attributes epistemic and normative primacy to the concept of illness. According to Stein, illness is experienced by the patient as four complex feelings: betrayal, terror, loneliness, and loss. “Betrayed by his own body, the terrified patient has lost the thread of the narrative of his life” (2007, 91), and the doctor’s most difficult job is to help him recover or reinvent his story. In this sense, we are experiencing a paradigm shift from an “evidence based” medicine to a “narrative based” one. Narrative-based medicine encourages substituting “skills deemed ‘scientific’—those that are eminently measurable but unavoidably reductionist—for those that are fundamentally linguistic, empathic, and interpretive” (Greenhalg & Hurwitz, 1999, 50). As a result, facts and values are not as sharply separated as in the former paradigm.

8. Old and new medical values

Khushf uses the debate on health concepts in order to point out how the present transformations in the clinical setting destabilize traditional understandings of medicine and health care. Ultimately, he thinks that the “classical medical ideal” cannot be sustained (2007, 25), suggesting that we are indeed experiencing a sort of Kuhnian revolution or “paradigm shift” in biomedical theory and practice.

Again, this way of thinking is entitative, as it suggests the image of a “clash” between some older and some new medical values. However, there is no need to think in such terms. Health problems are many and diverse; new problems will need new solutions, but we do not need to equate solutions and values. More often than not, what are termed “medical values” are good old-fashioned professional virtues, or reasons to choose a career in medicine (that is, the internal goods relevant to this profession). Because such medical values are not solutions, they are not necessarily affected by the emergence of new problems.

Actually, we could even argue that there are no typical facts (or values) of medicine. As we have seen in the previous section, the concept of disease is not the exclusive province of health care professionals, because it includes also “illness” (the personal perspective) and “sickness” (the social one). An obvious example of an allegedly “medical value” would be the patient’s life, in potential conflict with the patient’s autonomy (another alleged value, especially in those versions of bioethics in which the principle of respect of autonomy is paramount). Here again, the entitative sense of value is at work. If human life *is* a value, it is difficult to identify what is at stake in every clinical situation, because each case, each patient, is reduced to a particular instance of that generic human life that *is* a value. But if we stick to the possessive sense and say instead that (different) human lives *have* (different) values, it is easier to make further distinctions and realize that prolonging a particular life may be less valuable than other courses, on the basis of medical futility, the patient’s preferences, the demands of distributive justice, or on some other consideration.

Another set of candidates to the position of “medical values” would be those goals that are proper to medicine, or to the healthcare relationship. This is an interesting field of enquiry. Between 1992 and 1997, the Hastings Center carried out a well-known international study in order to re-examine those goals and set up new priorities. The research group settled on four goals:

1. The prevention of disease and injury and the promotion and maintenance of health.
2. The relief of pain and suffering caused by maladies.
3. The care and cure of those with a malady and the care of those who cannot be cured.
4. The avoidance of a premature death and the pursuit of a peaceful death.

Health, cure, care, and a peaceful death are of course valued by most people, but again there are problems if we think of them as entities. There is no easy way of precisely determining when the pursuit of health and cure should give way to the pursuit of care and a peaceful death. As the Director of the Hastings project notes, those goals embody potential tensions, especially in the care of the dying, because “the point when a person is considered to be critically ill, or dying, will in part be a function of the reigning medical and ethical values of a society, as well as of the available economic resources to respond to that person” (Callahan, 1999, 104-105). The subject of the alleged “conflict of values” is not and cannot be the health care professional alone, but society at large (including, of course, the patient). And it is not easy to specify what exactly those “values of a society” are that are so fundamental in order to separate life and death. What is sure, however, is that the “facts and values” (i.e., the valuing) we uphold when making health-related decisions are not natural, in the

sense that they cannot be described or distinguished without appeal to norms and cultural standards; rather, they belong to the *polis*, and as such are inextricably linked to political life.

9. Conclusion

Fact/value is a complicated distinction which at one level is obvious and important while at others, as we have pointed out, is much more problematical. The main upshot of our analysis is a rejection of naturalist accounts of bioethics, in which fact and value are neatly divided, in favor of a more relational approach, in which the dichotomy makes no sense as such. As we have shown (using Gracia's work as an example), "value talk" is becoming pervasive in the field; and many proposals of a methodology for moral deliberation in biomedical ethics rely on the fact/value dichotomy, much in the same way classical clinical method does. However, such dichotomy might be practically dispensable and theoretically untenable—not only because of the new developments in health care, as Khushf suggests, but also because of philosophical arguments dealing with value inquiry.

By separating two main, but clearly different meanings of the word "value", we suggest that the dichotomy is construed on the prevalence of what has been called the entitative or free-standing uses. These entitative uses raise problems of incommensurability and hierarchy, create a gap between administrative and clinical work, obstruct some methodologies in the clinical context, and encourage an opposition between the new and the old medical values. These difficulties can be avoided, or at least eased, by replacing the entitative meaning with the possessive use of values. Health care is an activity that generates and needs manifold values, but does not commit us to any given order of valuable things.

If concepts so fundamental in the philosophy of medicine as health and disease are widely accepted to be normative, a new methodology in biomedical ethics is needed, one that understands the distinction between fact and value in ways other than the classical, naturalist one. Gracia's proposal represents a step towards that direction, but further work would be necessary in order to clarify it.

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