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Values as 'modest foundations' for medicine

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Abstract

Medicine and healthcare have been around for thousands of years, but we seldom ask why they are so important. It seems self-evident that we should seek relief of suffering from some institution in the society in which we live and equally self-evident that each society should provide healthcare for its people at some level. Yet when we inquire further, we are driven to seek foundational answers to iterative questions, seeking answers at deeper and deeper levels. Ultimately, it seems best to accept the Humean refuge [1] and finish with some such statement as "Humans are like that" or "Societies can't function in any other way".

These Humean questions suggest that survival, security and flourishing are endpoints for such an inquiry and that medical (and many other) systems are built on these implicit foundations. The ways in which societies build relevant systems (such as medicine, welfare, law, transport, housing and so on) will differ strikingly, but common ground will still exist at the foundational level.

Acknowledging a commonality of foundations does not commit one either to a conservative normativity, nor to a loose relativism. Increasing activity at the level of the International Court of Justice makes clear that there is a possibility of consensus for judging the validity of the interpretations and enactments of foundational values in any society. The ideals of the American Declaration of Independence — life, liberty and the pursuit of happiness — are principles very similar to the foundational values of survival, security and flourishing. Person-centered medicine is inescapably based on theories of the person and must therefore be able to offer an account of what personhood is. Values underpin the philosophy and practice of medicine, including person-centered medicine, because they are foundations of personhood, as well as foundations of the societies in which each person lives.

Keywords

Discourse, evidence-based medicine, foundationalism, medical epistemology, narrative-based medicine, person-centered medicine, reform, values-based medicine

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Accepted for publication: 19 September 2012

Introduction

For every bad-news piece run by the media, there will be a good-news piece, a break-through on cancer, a heroic operation to separate twins, a new diagnostic measure, a dedicated doctor and his team working in a poor country. Doctors can be portrayed as heroes [2], just as they can be dismissed as villains. And there are countless achievements they can point to in the management of

cancer, coronary disease, tuberculosis, malaria, nutritional disorders — at least in developed nations.

So it is possible to perceive both good and bad in modern medicine. Like most dichotomies, both extremes are wrong and neither is exclusive of the other. Modern medicine is both good and bad at the same time. Most people want technical competence at times of medical need. The charming doctor who gently presides over unnecessary deaths because of incompetence is condemned for incompetence, not praised for charm [3]. Knowledge,

competence, wisdom and self-control are goods in medicine; empathy, communicative skills and gentleness are also goods, but from different domains. The 'good doctor' is supposed to be, therefore, knowledgeable, skilled, wise, self-controlled, empathic, communicative and gentle. We would doubtless like to see all these qualities in lawyers, policemen, politicians, teachers, bus drivers and our own children. We seldom find such a happy combination of attributes. Humans are essentially human, fallible, subject to moods, fatigue and self-protective instincts. To set the medical profession completely to rights would require a re-engineering of human nature. This is scarcely attainable, but if there are persistent perceptions of failure in some aspects of medical care, we should try to do something to address the real shortcomings.

Let us accept that there are failings, that scientific medicine can interfere with humane medical practice. Let us agree that there are some grounds for the complaints about poor communication, impersonal treatment, inefficient uses of therapeutic time and space, lack of social justice and so on. Or at least let us accept that these failings are legitimately perceived by those who complain. What can a reformer do? He can attack the problem at various levels. He can try to change societal expectations, a particularly thankless task. He can perhaps try to screen entrants to medical schools for empathy, motivation and moral sense — there is very little evidence that this has significant effect on the outlook and behaviour of graduates [4]. He can change the curriculum so that humane studies become important — this has been done in some places, but there is as yet no conclusive evidence to show that patients approve their graduates more than the graduates of other schools [5,6]. He can emphasise behavioural change in medical school and beyond, teaching a set of performative skills to medical trainees that may help patients to feel appreciated and respected — the problem here is that performative skills work best in set scenarios and may seem hollow or offensive in real life; there is evidence that they may not always enhance patient satisfaction [7]. Or he may try to do what other reformers in recent years have tried, which is to re-set the base or re-define the centre of medicine in order to remind practitioners, teachers and students of medicine's focal points.

This redefinition of the heart of medicine has taken various forms and has been variably successful. Would-be reformers have suggested that medicine should be humane [8,9], evidence-based [10-22], values-based [23-29], narrative-based [6,30,31], person-centred [24,32-34] or that we should concentrate on the function of medicine, on its role of care, as patient-centred care [35-37], holistic care [38] or team-based care [35,39-41]. There are many other semantic labels that attempt to shift the relationships of medicine to its knowledge base, its power base and its constituency. Thus, we have toyed with construing patients as clients [42] or consumers [43-46], doctors as providers [40,41] and contractors [47]. These are laudable endeavours, but do not stop complaints or tensions, nor the growth of critical literature, both popular and scientific [48-52].

EBM is one alternative that has received rough handling in recent years [11,13,17-19,33,34,53-60], yet retains status and authority in the face of much legitimate criticism. In its early days, it promised much. David Eddy predicted that a computer on every doctor's desk would simplify and standardise decision-making in the clinical consultation and that evidence would at once indicate appropriate treatment for each and every patient [61]. A hierarchy of evidences came into being. The RCT became its sovereign, its 'gold standard', the meta-analysis its platinum emblem. Clinical experience and expert opinion became suspect and appeal to the logic of mechanism (it should work because...) was sidelined in favour of statistical evidence of epidemiological benefit. Admittedly, a host of critical arguments required that EBM should surrender some of its high ground. Clinical experience and expert opinion were allowed back in, down the hierarchy, but acknowledged as having *some* weight.

We should never lose sight of the good that EBM has brought. It has undermined the false authority of fashionable eminence; it has persuaded clinicians to think about the nature of medical knowledge and the ways in which it is warranted; it has challenged teachers to think about medical decision-making and it has persuaded philosophers and sociologists of medicine to confront the challenges of positivism in delivering services essential to human welfare.

The achievements of medicine in the last 100 years are very considerable. Most people are familiar with the statistics of life-expectancy, infant mortality, infectious diseases, that are the stuff of justification for the size and cost of the health enterprise. Sophisticated health services are differently available in different Western countries, but by comparison with 19th century services modern populations are reasonably well served.

Yet despite the positives, there is a perception of failures, a perception that has remained steady for many years [62-65]. Authors may differ in their accounts of the shortcomings of healthcare, but there are some common concerns. Medicine is impersonal; it is scientific at the expense of being humane; its communication skills are inadequate; it is inefficient with its time; its practitioners are arrogant and too preoccupied with status and income; it is potentially corrupt and sometimes practices scientific fraud; it has sinister ties to pharmaceutical industries and technology companies; it attends too much to remunerative practice and too little to welfare and the illnesses of those in most need. In short, it has too much concern for its own welfare and too little social conscience, too scant a relationship to the humanity of those in need of care.

There is a fundamental difficulty for anyone who wants to change the habits of many lifetimes. Medicine has grown organically to meet needs and to incorporate and exploit an expanding science. Its roots can be traced back thousands of years and it has become a part of the fabric of any society. Medicine is pushed by the *vires a tergo* of tradition and habit and pulled by the *vires a fronte* of scientific technology and social aspiration. People expect some kind of medical services, wherever they are and they expect sophisticated services in Western societies, where technology flourishes the most. Patients and doctors are

people, shaped by cultures and individual differences. Students graduate from medical schools and move into the established cultures of hospitals and clinical practices. They may retain memories of the good things they were taught, but enculturation into the pragmatism of the clinic is a powerful shaping force. It changes the *habitus* of the evolving doctor, the distinctive combination of the individual attributes and acquisitions that constitute the individual at any time [66]. And its moulding force is as much implicit as explicit. Models of success, of survival, of comportment and behaviour, surround the neophyte as he or she passes further into the distorted world of the clinic, where the abnormal is normal and suffering is the stock in trade of its workers.

Part of the indignation about the power of the EBM movement seems to result from a wide realisation of incoherence and an objection to the word 'based'. Evidence may be a basis for medical practice, but not for medicine itself. While its influence lingers, interviews show that practising doctors in Sydney are respectful but reserved, recognising the importance of context and individual differences — their own included [67,68]. In a series of interviews with doctors associated with the Sydney Medical School in Australia, we encountered many variations of this theme. Here are 2 examples:

There are circumstances where that is a clear and substantial benefit for a treatment and I think it's not so difficult to discuss what to do. But I think a lot of the time the evidence is not so overwhelming or the benefits are small and there are minuses as well as the pluses and so the more finely balanced that decision, the greater the extent of the person's, kind of, philosophy and attitudes and things.

The encounter between a patient and a clinician is basically an encounter between 2 human beings and therefore it's primarily an issue of relationships and communication. There is the technical stuff which needs to clearly be fed into that and there may be things that we learn from research which can help clinicians know how to manage the relationship, but I mean essentially we are left with 2 people talking to each other and a large part of that is may be informed by the research, but it essentially is the art of being people, communicating and talking.

The second doctor is describing a version of person-centred medicine (PCM), in which a clinician and a patient encounter one another as persons. Most of the 19 doctors we interviewed made very similar observations. This is how clinicians encounter their daily praxis and how they deal with moral quandaries and dilemmas. This repeated emergence of person-centeredness has led Miles and Mezzich [34] to support Upshur's contention [59] that medicine needs no foundation, because it 'can operate well within a dynamic emergent framework' [34]. And it leads them to the same conclusion about patient-centered medicine.

But is it reasonable to leave PCM as emergent, without the need for a base? We think not, because we believe that there are deeper justifications for medicine than medicine itself and for that reason propose values-based medicine (VBM) as an underpinning for PCM, using 2 epistemological manoeuvres, one old and one new. The

newer one takes a 'Humean-Darwinian' approach to ethics [69,70]; the older adopts the Humean standpoint of repetitive questioning in order to find a foundational proposition beyond which it seems impossible or pointless to go [1].

The Humean-Darwinian approach to ethics is avowedly naturalistic. Hume insisted that moral values emerge from human desires or 'passions', modulated by 'reason'. Passions determine what we want to achieve; reason tells us how best to gain our desires and needs. The Darwinian component suggests that rational, social beings like humans will select ways of interacting that facilitate individual and group flourishing and that evolution will select forms of ethics that enhance survival capacity. When Hume and Darwin are brought together, as they are by Curry [70], the is-ought distinction and various forms of the naturalistic fallacy lose much of their force. To quote Curry:

Recent developments in game theory, evolutionary biology, animal behaviour and neuroscience suggest that Hume was right to think that humans have natural dispositions to act 'in the common good'. Evolutionary theory leads us to expect that organisms will be social, cooperative and even altruistic under certain circumstances.

What is happening in a functioning democratic society is indeed 'good' insofar as it permits evolution to continue and the common weal to prosper. But this does not mean that everything is for the best in this best of all possible worlds, nor does it mean that every society is serving human welfare to the optimum extent. The world is full of power blocs, whose elites exploit the weakest within their domains. Any society has its black spots of injustice, violence, corruption and exploitation. But established societies, with all their faults, offer some measure of stability to their members and presumably the practices, morals, beliefs and habits serve the ends of promoting some values that are held at a very deep level and which may be consistent between cultures.

Hume also gives us a hint about the way to search for those values. He suggests an iterative process of inquiry that seeks reasons for practices and beliefs, to the point where further search becomes pointless. He offers this example:

Ask a man why he uses exercise; he will answer, because he desires to keep his health. If you then enquire, why he desires health, he will readily reply, because sickness is painful. If you push your enquiries further, and desire reason why he hates pain, it is impossible that he can ever give any. This is an ultimate end, and is never referred to any other object...And beyond this it is an absurdity to ask for a reason. It is impossible that there can be a progress in *infinitum* and that one thing can always be a reason why another is desired. Something must be desirable on its own account, and because of its immediate accord or agreement with human sentiment and affection [1].

We think it is productive to follow Hume's method of iterative inquiry in a search for foundational values and then to consider how such values may play out in practice.

But we need first to explain further what we mean by values.

Values and axiology

Values, as we understand them, are the foundations on which we base our qualitative judgements of 'good' or 'bad' in ethics, 'beautiful' or 'ugly' in aesthetics. Values underpin our beliefs and commitments at deep levels of our minds and brains. They reflect our deepest needs and at this profound level, foundational values are common to all cultures and all times. This sounds like a highly contentious claim, but we believe that disagreement comes from a confusion in the discourse of axiology between the foundational values and their enactments in different cultures, different contexts and at different times. We tend to identify the choices and decisions people make as their values, instead of reflections of their values and thus to think that people and peoples have different values when their underlying commitments may be remarkably similar.

Let us try to explain what we mean, by repeatedly asking questions in the Humean fashion, about medicine as a public service. Why do we spend so much money and political activity on health services? Perhaps because people have come to expect that good government in a good society will provide adequate health services. But what do adequate health services actually do? They provide care and relief for people suffering illness. But why should society bother to do this? And somewhere along this line of questioning one is forced to say something like "Because there is no other way that a society can function" or "Because that is the way that human nature works." These may be unsatisfactory answers in some ways, but, as Hume suggests, 'Something must be desirable on its own account and because of its immediate accord or agreement with human sentiment and affection.' We believe, furthermore, that one can follow this process with almost any institution in society — law, education, housing, transport, business and so on.

The Humean iteration leads us to 3 basic values that seem common to all individuals and to a very high proportion of the world's cultures. First, we value *survival*. When confronted with drowning, we struggle to breathe again; when starving, we improvise to find food and water somehow; when freezing, we struggle to keep warm. Second, when we have the means to survive, we value ontological *security*, the predictability that protects our daily excursions and activities. We expect that other people on the street and in the workplace will not assault or try to kill us, that cars will respect pedestrian crossings and red lights, that building safety codes have been respected and so on. Third, we value the ability to transcend our daily lives, to enjoy sensory intellectual and spiritual experiences from the security that our society provides, to exercise the freedom to *flourish*. Survival, security and flourishing lie at the heart of our value systems and they are enacted socially in different ways in different cultures. The United States, France, Britain, Iran and China have different justice systems, for example, but each of them

serve to provide security by defining crimes and prescribing laws, processes and punishments that are codified and enacted in known ways. Societies may function with very different enactments, so long as they can secure the primal values attached to survival and security. In addition to safety, people seek freedom to pursue flourishing. Societies that work to guarantee survival, security and flourishing for all members represent the highest in human achievement. This is underscored and empirically supported by democratic peace theory [71], since the absence of war is one of the best guarantees of safety, security and flourishing.

This position tolerates many different kinds of culturally specific practices, but it is not necessarily weakly relativist. Chinese society, rooted in Confucianism, values self-restraint and collective wellbeing; the US Declaration of Independence talks of the central importance of "life, liberty and the pursuit of happiness" and a 'good' society should offer all these. The increasing activity and standing of the International Court of Justice suggests that there are widely shared views of what constitutes breaches of acceptable protection of the foundational values.

This is the position of modest foundationalism that we adopt and we do not see it as harmful, reductive or restrictive [72]. It is descriptive and aetiological and not normative. We believe that it helps to answer the fundamental question "Why have healthcare?" It encourages cross-cultural inquiry and understanding and helps us to appreciate the profound responses that societies generate when there are threats to health services or when health services demonstrate major failings. We have to disagree respectfully with Miles and Mezzich [72] when they criticise other models of medicine than person-centered medicine by insisting that "These models, however, despite their noble aspirations aimed at philosophical resolution, remain problematic in claiming for medicine largely singular visions predicated upon the specific viewpoints of individual schools of thought." VBM, in our particular model, does no more than provide a further logical basis for person-centered medicine by reminding us that the survival, security and flourishing that we speak about are all potential attributes of persons within the 'medical' context. It will not do to claim that person-centered medicine is based on theories of the person, but exclude some of the foundational features of personhood from the theory.

Values-based medicine has been suggested as a complement to EBM, but the most influential account of VBM differs somewhat from ours. Fulford has written extensively on the topic, basing his account of VBM on teaching students to elicit and respect patient preferences [23,24,28,73]. Preferences thus become proxies for values, a position that we respect, but do not follow. We believe that this model leads people to detect differences in values where they do not exist. Preferences are context-determined *expressions* of values. Values can be conceptualised as foundational needs, common to people in virtue of their personhood. Nearly everyone wants to survive, be secure and flourish, but cultures, societies and individuals have different approaches to meeting those

needs. Our model, therefore, provides a starting point for wide discourse, Fulford's a means to teach practices and skills. We endorse his program whole-heartedly, because we believe that the models are complementary.

Fulford outlines 10 principles of values-based medicine [73]:

1. All decisions stand on 2 feet, on values as well as on facts, including decisions about diagnosis (The "2-feet" principle).
2. We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (The "squeaky wheel" principle).
3. Scientific progress, in opening up choices, is increasingly bringing the full diversity of human values into play in all areas of healthcare (The "science driven" principle).
4. VBM's first call for information is the perspective of the patient or patient group concerned in a given decision (The "patient perspective" principle).
5. In VBM, conflicts of values are resolved primarily, not by reference to a rule prescribing a "right" outcome, but by processes designed to support a balance of legitimately different perspectives (The "multi-perspective" principle).
6. Careful attention to language use in a given context is one of a range of powerful methods for raising awareness of values (The "values blindness" principle).
7. A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people's values (The "values-myopia" principle).
8. Ethical reasoning is employed in VBM primarily to explore *differences* of values, rather than, as in quasi-legal bioethics, to determine "what is right" (The "space of values" principle).
9. In VBM, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in decision-making (The "how it's done" principle).
10. VBM, although involving a partnership with ethicists and lawyers (equivalent to the partnership with scientists and statisticians in EBM), puts decision-making back where it belongs, with users and providers at the clinical coal-face (The "who decides?" principle).

These principles bring together suggestions from many fields of bioethics, philosophical ethics and communication theory. Fulford is frank about their particular application to psychiatry [73], but common sense allows their relevance to clinical practice in general. The strength of Fulford's approach lies in its fitness for teaching, the ways in which the 10 principles can be specifically taught to medical students at all stages.

Practical applications

We quote at length from a previous article in order to summarise what we feel to be the essential message of this paper [27]:

So how does this play out in medicine? First, as discussed above, our model provides us with a way of understanding why we have health systems at all - all health systems in all cultures are expressions of the desire for safety, security and flourishing. We have health systems to save life, to preserve or restore function in the face of trauma or disease, to provide access to skills for those with health needs. And these things matter because people want to go on living without suffering, want to realise or extend their capabilities, want help when illness threatens or reduces their quality or quantity of life. In this way, values-based medicine provides us with an abductively-derived 'base' for medicine that other systems, such as evidence-based medicine, simply cannot provide.

Second, our model can help us to understand why particular health systems have evolved in particular ways and why health systems might differ in different settings. Take, for example, the differences between the health system in the US and the health system in the UK. In one, a heavily socialised system makes good to modest services available for all. In the other, the world's most sophisticated services are available for some, basic services for others. In parts of Africa, there may be very basic services for some, no western-style services for others. Yet in each country, there are organisations and groups that seek to preserve lives, to relieve suffering and to return people to their capabilities. The priorities differ considerably between rich and poor countries, between rich and poor people. The Texas Heart Center has a quite different philosophy to Medicine sans Frontieres. One is a business that depends on capitalistic theories of enterprise, selling survival, security and flourishing at superb level and high price; the other a charitable enterprise that tries to deliver survival, security and the capability to flourish to some of the most vulnerable people in the world, without profit. Both owe their continuing existence to individual and cultural values, however differently they may be expressed in different socio-economic contexts. Their translation into action in different ways has produced the societies and cultures we know. Other foundations might have produced better ones, but that is to enter the domain of speculative ethics, to recross the naturalistic barrier into a realm of thought experiment.

This kind of modest foundationalism thus develops into a form of values-based medicine (VBM) with broad implications, where the word 'based' is used deliberately to recognise that all healthcare is justified by 'basic' values. It allows the incorporation of EBM, narrative-based medicine, patient-centered care and person-centered medicine, but also sits comfortably with public health (including its ethics). It respects cultural differences, preferences and ethnomics, the increasingly important intersection between ethics and economics [74,75]. But it always demands reflective equilibrium. By recognising their deep, implicit presence we offer practitioners and students a direction for the exercise of wide reflective equilibrium, the process whereby formative experience, moral theory, moral reasoning and moral knowledge are brought to bear on an ethical quandary [76-78].

This leads to the third use of our model. By understanding why particular health systems have evolved as they have, we have the basis for a critique of these systems at all levels, to include its patients, bureaucrats, healthcare workers, researchers and so on. Our capacity to understand (and empathise) provides us with one component of the wide reflective equilibrium according to which we can judge our own healthcare practices and those of others.

Conclusion

Values, in this paper, are conceived as the implicit, often remote, justifications for our beliefs and choices. Beliefs and choices are the enactments of values, rather than the values themselves. Our own previous empirical research leads us to agree with the words of the Founding Fathers in the American Declaration of Independence. We value life, liberty and the pursuit of happiness - in other words, we look to our society and its culture to provide us singly and collectively with means of survival, institutions to insure our security and opportunities and freedoms for human flourishing. Once again, we take the liberty of quoting from previous work [27]:

VBM, couched in these terms, provides no cut-and-dried answers to the perennial problems of bioethics. What it might do, however, is provide a conceptual framework and a heuristic for understanding, reflection, discourse and dialectic when there appear to be irreconcilable differences between practices and beliefs, between possibilities and realities. VBM incorporates EBM, patient-centered care, public health, bench-top research and person-centered medicine. It has some claims to be the basis for medical education at all levels, for establishing standards of practice and for reflection on ethical quandaries at individual and population levels. In no way does it compete with person-centered medicine for rhetorical priority, but it may offer a further justification for value-laden theorising in medical epistemology and practice. Some may even prefer to use the concept in the dialectic of revision between the 'scientific' and the 'humanistic' extremes of healthcare theory.

We believe that our 'modest' and aetiological foundationalism serves to strengthen Fulford's model by providing justifications for taking the trouble to enact his principles in clinical practice. It defends respect for preferences, but asks the student, the researcher and the practitioner to enter into the social and psychological processes whereby the individual arrives at different preferences from similar starting points to her own. It helps the processes of empathy and sympathy by recognising the common features of humanity and personhood.

Conflicts of Interest

The authors declare no conflicts of interest.

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