VALUES-BASED MEDICINE AND MODEST FOUNDATIONALISM

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ABSTRACT

Values-based medicine can be interpreted in economic terms as the medicine that delivers the most benefit for a given cost. But values have another meaning in philosophy. They refer to the basic commitments that justify judgements, beliefs and practices, both at community and personal levels. The study of these kinds of values is axiology, and they are the subject of this article. There may be debate about the ontology and epistemology of values of this kind, but this need not stop their empirical exploration, nor their deployment in constructing a theoretical basis for health care and a framework for medical practice, medical research and medical education.

We suggest that all peoples subscribe to three foundational values – survival, security and flourishing – and that these foundational values are expressed by way of concepts, systems, principles and practices that may differ substantially from culture to culture. Many ethical quandaries can be better understood, even though they may remain unsolved, by reference to the foundational values that people can agree upon. It becomes clear that disputes and dilemmas arise because of differences in the ways that values are expressed in cultures, particularly in pluralist societies. Yet agreement can be obtained about foundational values, and dialectic may be better focused by returning to them in discussions involving individuals or groups with different preferences.

Values-based health care has strong claims to prior logical status as a justification for the whole enterprise of health care, and values-based medicine is a part of this larger
domain. To accept VBM is to accept subtle but important differences in the conduct of medical practice, medical research and medical education.

KEY WORDS

Values; values-based medicine; evidence-based medicine; medical education; medical research; medical practice

THE RISE OF VALUES-BASED MEDICINE(S)

“Evidence-based medicine” (EBM) has now been part of the dominant biomedical discourse for twenty years. EBM was initially introduced as a way of standardising clinical practice and moving away from idiosyncratic clinical judgment based on anecdote and experience (1). Since then, the teaching of its principles and practices has become a central part of medical education, and EBM now plays a major role in the setting of research priorities, the production of clinical and public health practice guidelines and the day to day work of clinicians and public health practitioners (2).

While EBM has had considerable success in standardising medical practice and improving patient outcomes, it has also been the subject of pedagogical, professional and political debate. Criticisms have focused on the traditional EBM hierarchy that privileges randomised trials over all other study designs (3); on practitioners’ slavish, and often defensive, adherence to evidence-based practice guidelines (4) and on the tendency for EBM to de-privilege both clinical expertise and patient values (5).

Concern about the de-privileging of patients’ values has manifested itself in the emergence or increased popularity of a number of “alternative” frameworks for medical practice—each of which might be considered a form of “values-based medicine”. The “holistic medicine” movement arose in part as a response to perceptions of “impersonal” medical care that was not sufficiently cognisant of the whole patient (6). “Narrative medicine” emphasises the importance of “narrative competence”—the capacity for a doctor to grasp, honour and act upon the meanings of a patient’s narrative (7). “Patient-centred medicine” emphasises the welfare and identity of each patient as the core emphasis for medical practice.(8-11) “Humanistic medicine” seeks to remind clinicians of the contributions that the humanities and human sciences can make to medicine and its practices (12, 13). More recently, various versions of “values-based medicine” (13-17) have emerged. There are two schools of thought. For some, values have a material existence, and can be expressed in monetary terms, and benefits can be measured in terms of measures such as quality-adjusted life years (QALYs) (17). For others, values represent moral entities that underlie beliefs, choices and decisions in the face of moral dilemmas (13-16, 18-22).

THE TROUBLE WITH VALUES-BASED MEDICINE(S)

While these various forms of “values-based medicine” might provide an important counter-balance to naïve EBM, they have not gained nearly as much traction in medical practice as has EBM. There are several possible reasons for this. It is possible that the
dominance of EBM is a result of the success that its proponents have had in touting it as a “new paradigm” in medical education and practice (23). Others trying to account for the dominance of EBM have argued that power has become concentrated in the hands of those who accept and have expertise in the principles and practices of EBM, and that EBM has achieved “cult status” such that it cannot be questioned (18).

It is also possible, however, that the various values-based medicine(s) (VBM)s have failed to take hold because, unlike EBM, they have not defined and operationalized themselves sufficiently, thus leaving practitioners with only the vaguest idea of how they might be put to use. While the meaning of the word “values” might seem intuitively obvious, the term ‘values’ is complex semantically, just as values are complex in practice. The word in use slips between meanings. Because it refers to something foundational, we assume that we know its meaning when we use it or hear others use it. But a profound difficulty arises when we try to pin down this meaning.

To solve this problem, some schools of values-based medicine have taken an economic approach, reducing “values” to “preferences” and operationalising VBM using various clinical decision-support systems. The problem with this approach is that it is based on the economic theory of cost-benefit, where costs may be monetary and benefits measured by constructs such as quality-of-life adjusted years (QALYs) (17). This is a perfectly valid use of the word, but we do not use it in this way. When we use it, we refer to moral and ethical values that justify the reflective choices of people engaging with moral quandaries.

AN ALTERNATIVE (NON-ECONOMIC) ACCOUNT OF VALUES

What is needed, therefore, is a richer and more sophisticated account of values and how they might be operationalised in medicine. We propose an alternative (non-economic) account of values that has the following features:

1) It is based in axiology;
2) It assumes modest foundationalism;
3) It assumes that values exist on a continuum; and
4) It assumes a transformational relationship between individual values and the values of communities in which they live.

Next we will describe this model of values. We will then propose a values-based account of the justifications for medicine and the health system generally, and suggest how these insights might be incorporated into clinical and public health practice, medical research and medical education.

Axiology

Axiology is the philosophy of values, whether they are deployed in ethics, aesthetics, economics, politics, religion or war (13, 14, 16, 19, 24-33). It is the philosophy of judgement, of taste, of preference and comparison in all these fields. It is more than ethics, aesthetics, economics and the rest, because it seeks to provide philosophical foundations for all of them whenever evaluative judgements are applied or called for.
Axiology can be said to have problems with both its ontology and its epistemology. There is debate, on the one hand, about the ontological status of values, about whether they are natural properties of the objects of valuation, or are constructs of the individuals and societies that do the valuing. On the other hand, there is debate about their epistemological status, about the nature of the justifications that might support the epistemological standing of values. People like Hume (34), Kant (35) and Ruskin (36) have written as though there were objective standards for aesthetic taste. Some philosophers, such as Bentham (37) and Sidgwick (38), have seen hedonism as a criterion for broader evaluations; others have favoured eudaemonic criteria, seeking value in human flourishing (20, 39). Flourishing is a broad church, leading a number of thinkers to espouse value pluralism (40, 41) to include knowledge, friendship, virtue and virtuous actions, justice and a just society. There is also dispute about the locus of values. Are things to be valued because of their intrinsic attributes? Or does their value lie in their instrumental use? Dewey (42) dismisses this difference by arguing that means and ends are so linked that instrumentality is absorbed into the good ends that are sought. The means matter less than their ability to resolve dilemmas. Finally, there is disagreement over the ontological status of value statements. Do value claims refer to a real property of their objects, or do they simply reflect emotional responses or personal preferences?

Despite all these open questions and uncertainties, values continue to play a significant part in aesthetics and bioethics at least, and debates about the ontological status of values and their locus should not prevent empirical research into the perceptions that people have about the values they hold, nor need it inhibit attempts to clarify and model values and value-judgements within specific fields such as medicine. The values-based medicine movement exemplifies this focus and interest.

Modest foundationalism

But what does it mean to “clarify” and “model” a person or community’s values? We would argue that this involves not just elucidating desires and needs in particular situations, but also recognising that these wants and needs stem from a set of foundational values-are the irreducible goods that humans universally accept as components of an acceptable life. That’s a strong claim, but one we want to press, because, at the broadest and thinnest extent there do seem to be some categories that most people in most cultures regard as important. These include at least the satisfaction of survival needs, the maintenance of ontological security, and the possibility of human flourishing through self-development and the availability of opportunities for spiritual, aesthetic, moral, cognitive and physical growth.

Cultures may differ radically in the ways they express their basic values. Most seek ways to insure adequate food and water, shelter and nurturing to allow individual survival in social collectives. Most provide rules, customs, laws and justice systems to insure a sense of security, together with housing, traffic systems, employment and support for the unemployed and poor, although each culture will have distinctive ways of defining and materialising security. Similar comments can be made about human flourishing. Religion, the arts, socialising, recreations and sports help people to achieve a sense of transcendence, spiritual release and satisfaction, but the emphasis on each and the expression of each may once again differ markedly (43).

Nevertheless, most individuals in most cultures will register a concern about human survival, security and flourishing. They have emotions of loss when loved ones die; they
experience fear and suffering when they face their own deaths; they value life in one way or another. They feel fear and instability when faced with lawlessness, with the insecurity that follows a natural disaster. They take pride and pleasure in their artistic, literary or religious culture, the identifying elements of their capacity to flourish, and they resist the destruction of their cultures. The practices by which these basic values are operationalised may be very different, even incommensurable (female genital mutilation, alcohol drinking), but the foundational justifications for practices and choices can be traced back to the same broad abstractions.

In this article, then, we adopt a stance of modest foundationalism, acknowledging that foundationalism bristles with intellectual problems. The very modest form that we adopt uses iterative backward interrogation to establish ‘a point beyond which it seems impossible to go.’ Like most modest foundationalists, we recognise that our ultimate beliefs are defeasible by future knowledge, and that inferences from foundational beliefs are ultimately probabilistic. To seek the foundations of any discipline or enterprise, we need to ask repeatedly “What justifies this?”, until we reach a level at which we can only answer something like “Human nature is made like this”, or “Societies value these things, and that is all we can say.” Perhaps we may be able to say more as neurosciences advance; these claims are defeasible. But they offer us a starting point from which to proceed with inferences that may lead in different directions, but point back to the same foundations.

A values continuum

Consideration of foundational values alone can take us only so far in trying to understand what matters to people and why they do what they do. Values are based ultimately in abstract notions (such as survival, security, flourishing), but manifest in discourse, acts, choices, preferences, judgments, beliefs, conformities and resistances. There are way-stations between the abstractions and the manifestations, points on a continuum which operationalise the abstractions into the circumstances and actions of daily life. The term ‘values’ can therefore have a wide field of reference. This does not make the word useless-through-vagueness, but it does require us to understand its complexity.

We might choose to explore the values continuum from either end, but we propose to start at the operationalised extreme, and to track back more deeply toward the foundational values at the most abstract end of the spectrum. Let us begin by taking a concrete example of ‘values-difference’. In some Islamic countries, theft may be punished by amputation of one hand. In Western liberal countries, theft is dealt with by detention, punitive perhaps, but also ‘corrective’. Now these appear to be very different ways of handling the socially disruptive crime of theft, and might therefore be interpreted as manifestations of different underlying ‘values’. They are, in essence, practices that are based in values. In one society, retribution and the punitive exertion of the authority of the state are seen as more effective (more valuable) means to insure social compliance; in the other, the values attached to the human body and to the possibility of reform determine a different kind of punishment. Inevitably, both cultures seek to achieve something perceived as a public benefit. They have in common principles that include a respect for laws, policing, sanctions and conventions.

And underlying the principles is a system, also based in values, that conceptualises justice in ways appropriate to the beliefs of the relevant culture. But why have a justice system at all? Presumably because societies have to generate some consistent rules for
their members to observe, so that each society can provide enough stability and predictability (44). Social groups and cultures need to have as an underlying concept a general commitment to an implicit or explicit contract for the maintenance of social order. But why bother with social order? Why not allow the war of all against all (45)? Because people value some form of security, some degree of certainty about their own and their children’s survival. And why do they value security? Because that’s the way a social or cultural grouping has to be if it’s going to survive. Concepts of order, systems of justice, principles of law, rules, guidelines, laws, law enforcement – all have their logical beginnings in the foundational value of or need for security.

Now this model suggests that we can talk legitimately about values at any of perhaps 5 levels, starting at a foundational level. Using the example outlined above, we can represent the levels and the relationships between them in the following way (Figure 1):

![Diagram](image)

**Genesis of values**

Cultural values and habits are internalised in individuals, and expressed in different ways (Figure 2). Cultural values, recognised fields of practice and individual differences make up the habitus and field that Bourdieu described (46), the highly situated and contextualised individual within the discourse communities he or she inhabits, discourse communities that in turn exist within the framework of the dominant culture. Discourse communities are groups of people with common interests and commitments, that construct ways of speaking that reveal a shared vocabulary of terms with situated meanings, shared commitments, shared narratives, iconic texts and modes of comportment (22, 47). The individual, drawing on and feeding back into his or her culture in the way that Bhaskar refers to as the transformational model of society (48), forms value-based concepts from this raw material and integrates them with value-based systems (such as health, justice, fairness, pluralism, racism, capitalism), and then decides his or her relationship to encodings of the value systems. He or she must decide how to respond to laws, customs, beliefs, mores that dominate the culture and discourse communities in which he or she has membership, constructing value-based principles on which to act. Finally, individuals put into actions as value-based practices the decisions that flow from reflection about these relationships, actions that may express conformity or resistance, judgment, questioning, approval, disapproval and so on. The word ‘values’ can refer to deeply held commitments that may never have been the object of reflection, and equally to the practical manifestations of these commitments. It thus refers to the entire field set out in Figure 2.
EXPLORING THE VALUE-BASE OF MEDICINE

This reconceptualisation of values leads to a different way of thinking about the justifications for medicine and the health systems generally. Evidence-based medicine, holistic medicine, patient-centred medicine, values-based medicine – each of these terms is at the centre of a vigorous discourse that claims epistemological and moral priority as a practical philosophy of health care. To us, the key question raised by each discourse concerns its right to claim something as a foundation, a base, for the theory, pedagogy and practice of medicine. In particular, the term ‘evidence-based medicine’ suggests that medicine is based or founded on evidence, that evidence is the ultimate justification for the existence of a health system. ‘Values-based medicine’ seems to make the same claim, while ‘patient-centred medicine’ and ‘holistic medicine’ seem to make more modest claims about the ways in which medicine should be practised. The word ‘based’ is the key one to examine.

So what happens when we interrogate medicine according to our model of values? Medicine is justified because it relieves suffering and restores or preserves health. Why does suffering or health matter? Because suffering and bad health limit our agency. And why does that matter? Because, as humans we value our ability to flourish, and without agency we have no enablement to flourish. And what do we need to support our flourishing? We need to insure our survival with food, water, shelter, warmth and so on; and we need a degree of security so that we can predict what will happen from day to day, from situation to situation. And why do survival, security and flourishing matter to us? Simply and foundationally because we cannot do without them. Like language, they seem to be an essential part of being social humans.

This argument, then, leads us to claim that medicine is ultimately based in values, in foundational values of survival, security and flourishing. Medicine may be practised in different ways and health services may be delivered differently in different countries, but the justification for having the services, for funding them, for taking them seriously, is their capacity to ensure survival in the face of illness, to provide security when illness strikes, and
to restore health to ill people so that they can regain agency and the capacity to flourish as human beings (Figure 3).

**VALUE-PLACEHOLDINGS IN HEALTH**

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Figure 3.

This leads to a somewhat different critique of evidence-based medicine. Rather than focusing on specific weaknesses of the EBM model, we argue that evidence cannot provide a basis for medicine. If we interrogate evidence itself, and ask what justifies the seeking of evidence, we can answer that evidence is worth seeking *only* because it enables more accurate and more beneficial practice of medicine. The gaining of evidence is justified by whatever justifies medicine. It is not an end in itself, and it is certainly not the basis or foundation of health care or medicine. It does provide (and always has provided) a basis for *practice* in medicine. Evidence justifies medical beliefs that underpin the ‘best’ choices for treatment and management. There can be little argument with claims for the desirability of ‘evidence-based practice’.

**PRACTICAL APPLICATIONS**

The VBM that we advocate brings particular perspectives to bear on clinical practice, research and medical education

**Clinical practice**

A clinical practice based on values is practice that remains constantly aware of cultural interpretations of the foundational values. By recognising that different cultures and different groups within societies play out foundational values in different ways, VBM recognises and respects the common needs that all people have for survival, security and flourishing. Like patient-centred care, it responds to individual differences. At the same time, because it exists within a particular culture, it remains alert to differences that go beyond culturally reasonable standards, and which might result in harms that are unforeseen (and perhaps unforeseeable) by the choosing agent. Anne Fadiman has described the case
of a Hmong child with epilepsy, whose family could not accept conventional medicine, but turned at length, after much distress in an unfamiliar system, to a traditional healer (49). Distress was not confined to the Hmong family. The treating clinicians also experienced frustration and disappointment at their inability to convince the family or treat the child effectively. VBM will not solve the ethical or emotional problems of such cases, but it will provide a means to understanding. All parties seek to express the same foundational values within the cultural frameworks they can believe in and trust. However different those expressions may be, everyone is seeking to achieve the same foundational needs. Being sensitive to cultural practices reaches one level of understanding. Going beyond that to accept the unity of goals that all peoples have reaches to another and deeper level. These insights may not change what is done in any situation of moral difficulty, but they provide ways to examine difficult issues such as end of life, or abortion, or the treatment of Jehovah’s Witnesses, or futility, or any of the other grand dilemmas that figure large in ethical texts and teaching sessions. It requires careful examination of the ways in which foundational values are playing out on the part of patients, families, health care workers, cultural groups within pluralist societies, or any of the other interests that are invested in health care.

Research

Research generates the evidence that constitutes EBM, but it is not an end in itself. Mapping the human genome has been a fascinating enterprise, and one that expresses the capabilities of modern technology. Mechanisation of genetic profiling promises to lead to personalised medicine, tailored to the individual genetic make-up. But whose survival, security and flourishing will be enhanced by this technology? Will it benefit one country or one section of society at the expense of another? How will genetic laboratories cope with the load of profiling whole populations, which will have to be done if equity is to be observed? Cutting-edge research is exciting and prestigious, but always needs to be related to the foundational values that justify it.

Education

VBM does not question the importance of the science and evidence that are important for medical practice. What it does is to emphasise that the whole health care enterprise expresses a commitment to foundational values, that it would not exist in its present form without an appeal to those values. It recognises that health care systems in other cultures may be different in detail, even in principle, but are at heart justified by the same values. At the heart of our recommendations is the repeated questioning of medical students and of graduate students: “What is it that connects this part of your learning or your practice to the foundational justifications of health services? In what ways can this knowledge serve foundational needs for survival, security and flourishing?” These questions are as relevant to the practice of medicine, to medical research, bioethics, public health and health administration as they are to the pedagogy of medicine.

CONCLUSION

Medicine is justified by the values we assign to foundational needs of survival, security and flourishing. Its telos is the welfare that comes from healing, caring, supporting, comforting in the domain of illness. Disease, age, pain, disability, trauma, mental illness – all
fall within the ends of medicine. These existential threats and challenges affect us all at some time in our lives. A health service is a specific part of our culture and our expectations. When natural disasters occur, developed countries send medical teams and medical aid, as well as food, water, shelter. We value life, well-being, a possible future. We measure our culture in part by the access it allows to health care. It is this attachment to foundational values that justifies medicine, and makes sense of the efforts made to seek evidence that may make services better.

Values thus have a much stronger claim to be called bases for medicine and health care generally. They deserve further examination. They are complex and worth understanding in their complexity and richness. We commend the formulation of values set out in this article as a means of understanding and explaining what we mean by values-based medicine. We applaud and support Fulford’s efforts in this field, but we seek to move well beyond a conflation of values and preferences, beyond a worthy exercise of intersubjectivity between doctor and patient. Priorities, preferences and choices are manifestations of values in action Values-based medicine would not seek to replace medicine’s science and evidence with something vaguely humanistic. It would retain science and evidence in full, because the foundational values that support the medical endeavour justify refinements in science and evidence.

BIBLIOGRAPHY


