

Introduction

Many Voices: Human Values in Healthcare Ethics

In an age of "ethics with everything," it may come as something of a surprise that there should be a need for a new reader on healthcare ethics and human values. In fact, this book is intended as a counterpoint (some might see it as a challenge!) to the growing legalism in many areas of bioethics. This quasi-legal ethics, as we will call it, is based on and gives expression to particular values (such as autonomy of patient choice). As such, quasi-legal ethics has been, and remains, an important part of bioethics' response to the ethical challenges of technological advance in medicine. We will give a number of examples of the importance of quasi-legal ethics later in this Introduction. What is needed now, though, we will argue, is to draw together and to strengthen those aspects of bioethics which, in contrast to quasi-legal ethics, make central not particular values, but *diversity* of values.

It is the diversity of human values operative throughout healthcare that this book aims to illustrate. Hence the majority of contributions – canonical, newly commissioned, and first-hand narratives – are organized not according to "issues," but according to the main stages of

the clinical encounter: they run from Staying Well (Part II), through Falling Ill (Part III), First Contact (Part IV), and Deciding What the Problem Is (Part V), to Negotiating a Treatment Plan (Part VI); and from there to Continuing Contact, either Getting Well (Part VII), or Chronic Illness, Disability, Deformity, Remission, and Relapse (Part VIII), and, in our final Section, to Dying (Part IX).

In contrast to quasi-legal ethics, we will use the term "healthcare ethics" to cover the diverse strands of scholarship and practice in bioethics, which, increasingly, start from and seek to make central the rich diversity of human values.¹ Healthcare ethics, understood in this way, and quasi-legal ethics are not sharply distinct. They represent poles of bioethical thinking, which, in theory and in practice, are woven together in varying proportions. There are, though, a number of important differences between them, which, if both are to make their proper contributions to a balanced bioethics, it is important to keep clearly in mind.

In this Introduction, therefore, we set the contributions to this book in context by highlighting some of the key differences between

quasi-legal ethics and healthcare ethics, so defined. These differences are summarized in table I.1. As this indicates, and as we will describe in this chapter, quasi-legal ethics and healthcare ethics differ in their aims and in their scope of application, in their underlying conceptual models of medicine, in the use they make of ethical reasoning, and in their practical applications. The features of healthcare ethics are further illustrated by the readings from contemporary authors in Part I (Multidisciplinary Approaches). But it is in the remainder of the book, in the stages of the clinical encounter set out in Parts II-IX, in the many voices of patients, carers, and professionals, that the human values at the heart of healthcare ethics are brought fully into focus.

Aims

Bioethics developed originally, mainly in 1960s' America, as a response to the rapid growth of biomedicine. There were, no doubt, other factors at work. This was, after all, a period of

rapid social change in all areas of life. But in medicine the particular challenge at this time was the emergence of new and more powerful technologies. With these technologies the "can do" of medicine expanded beyond all expectation. But with an enlarged "can do" went new and more urgent questions about what medicine *ought* to do. It was as a response to these questions that bioethics was born.

From regulation to partnership

Given the origins of bioethics, as a response to the growth of biomedical technology, it was natural that its initial aims should have been, in effect if not in intent, regulatory. Biotechnology, in itself morally neutral, was seen as being in need of control if it was to be directed to good purposes rather than bad. Again, wider social changes were important here: the rejection of received authority, widespread political cynicism, and loss of faith in the executive. In medicine the effect of these changes was a loss of confidence in its powers of self-regulation as an independent profession. Bioethics, corres-

Table I.1 Summary of differences between quasi-legal ethics and healthcare ethics

	Quasi-legal ethics	Healthcare ethics
Aims	Regulation Advocacy of particular values	Partnership Respect for diversity of values
Scope of application	Treatment Secondary care	Whole clinical encounter (including diagnosis) Primary (as well as secondary) care
Conceptual model of medicine	Medical-scientific model (fact-based)	Healthcare model (fact + value-based)
Ethical reasoning	Substantive ethical theory Value content	Analytic ethical theory Empirical content
Practical applications	Ethical rules Law as external regulator	Ethical process Law as framework for self-regulation
	Communication skills executive	Communication skills substantive

This table summarizes the differences between quasi-legal ethics, as it developed in response to the challenges of biomedicine, and healthcare ethics, as defined in this volume. Most of these differences are differences of emphasis. But the difference in value commitments, respectively to particular values (quasi-legal ethics) and to diversity of values (healthcare ethics), is a difference of kind (see text). It is the diversity of values operative at all stages of the clinical encounter that the readings in this volume seek to illustrate.

pondingly, developed its role on the model of moral guardian, protecting a vulnerable public from the predations of a technology which, otherwise, would run out of control. Biomedicine, with its new armoury of powerful technologies, required regulation. Bioethics would regulate it.

Regulation has been, and continues to be, an important aim of bioethics. The large and still growing library of codes and declarations, local, national, and international, has raised ethical awareness. In some cases, too, particularly in very adverse regimes, they have been effective in preventing abuses of medical power (Fulford and Bloch, 2000).

There is a growing feeling, though, that at least in some areas, regulation may have gone too far. In research ethics, for example, the requirements for consent adopted by some authorities are so elaborate as to be, in practice, unworkable. Researchers, therefore, are beginning to ignore them: not out of a desire to sidestep good practice, but because over-regulation, in this area, is perceived as a *barrier* to good practice (Osborn, 1999). Similar concerns, as we describe in more detail later in this Introduction (in the section on Practical Applications), have been surfacing in relation to confidentiality in mental health. Bioethical regulations aimed at promoting confidentiality have become so out of touch with the realities of practice, notably for multidisciplinary teams working in the community, that practitioners (social workers as well as doctors) have started to ignore them (Watson, 1999).² Good practice, again, is seen as being inhibited rather than promoted by over-zealous bioethical regulation.

Healthcare ethics differs from quasi-legal ethics in aiming for partnership rather than regulation. The difference is one of degree rather than kind. Regulation remains important. But the rules of engagement, which our codes and declarations embody, should be aimed as much at facilitating good practice as at preventing bad.

What does this mean? First, regulations, in so far as they have a role, should be framed to reflect the contingencies of real-life clinical care. Good practice is not promoted by unrealistic standards. To the contrary, if the standards

set are unrealistic, there is a real danger that well-motivated rule-breaking will let in just those abuses of medical power that bioethics has, properly, sought to prevent. Good practice, it should be said, can of course be frustrated by many factors external to the context of immediate clinical care, factors such as inadequate training and lack of resources (Agich, 1993). Such factors may thus be a proper target of ethical action by practitioners. Our codes should endorse such action, therefore, but they should not *require* it unless it is within the reasonable power of those concerned.

For those committed to a regulatory aim of bioethics, healthcare ethics, in requiring codes of ethics to be practically realistic, may appear to be taking the heat off practitioners. As Julian Savulescu (2001), a contributor to this volume (see chapter 14), has pointed out, ethics committees are at increasing risk of taking a paternalistic stand that is deeply inimical to the autonomy of patient choice. And individual cases of intrusive regulation are indeed far from uncommon (Dickenson and Fulford, 2000: ch. 6). The lesson they point to is not that we should abandon regulation. It is, rather, that what *counts* as good practice is far less settled than many in bioethics have recognized. In such cases, that is to say, what is good practice from one person's point of view may not be good practice from another person's point of view; and not because one is right and the other wrong, but because their values as such are, simply, different. Such cases, then, point to the importance of diversity of human values in healthcare.

From particular values to diversity of values

Closely related to the moral guardian model of bioethics, protecting patients from biomedicine, is that of the bioethicist as advocate, promoting patient choice. Like the moral guardian model, advocacy of patient choice was important in the early days of bioethics. At that time, faced with the growing power of biotechnology, a strong counterbalance to the established authority of medicine was needed. Hence medical paternalism, motivated by principles of beneficence, was counterbalanced by a principle of patient autonomy. To the accepted wisdom of "doctor knows

best" was opposed the strong principle of "patient knows best."

Patient autonomy is a strong principle essentially because of the primacy it gives to patients' values. Against a background of widening technological options, it makes the patient, rather than the doctor, the ultimate arbiter of what is "for the best" in a given clinical (or research) situation. In the "doctor knows best" model what is "for the best" is the doctor's call. In the "patient knows best" model it is the patient's call. The doctor has a responsibility to inform, even to advise, but not to choose on the patient's behalf. In much bioethical thinking, however, respect for autonomy of patient choice has become a value in its own right. There are important exceptions, individual and collective. The very name of the Society for Health and Human Values, for example, of which one of us (TM) has been President, suggests that even in the early days of the field there were alternative conceptions of bioethics. But many in bioethics, nonetheless, have come to see themselves as campaigners for autonomy.

Campaigning has an important place in ethics, of course. In chapter 1 Susan Sherwin distinguishes feminist ethics from medical ethics just in its campaigning stand against what she calls "the structures of oppression." There would indeed be little practical harm in campaigning for patient autonomy if patient autonomy were, as "western" bioethics has tended to assume, a universal value. But it is not. To the contrary, attitudes to autonomy vary widely from culture to culture (Blackhall et al., this volume, ch. 29). As the Egyptian psychiatrist and ethicist Ahmed Okasha has pointed out, autonomy is actually at odds with the values of many "non-western" cultures (Okasha, 2000). The imposition, therefore, of supposedly universal codes of ethics based on autonomy in such cultures, although well intentioned, is blind to the values of those concerned.

These observations on autonomy illustrate the wider point that campaigning for particular values in ethics, especially if combined with a legalistic "rules and regulation" approach to implementation, risks being counter-productive ethically. This will be necessarily so where the values that are advocated clash with the values

of those to whom the rules and regulations apply. The cases noted above mainly involved clashes of values primarily between western and non-western cultures. But it is important to recognize that such clashes are endemic to many areas of healthcare, arising as they do in any situation in which human values differ.

In some areas of acute "high-tech" medicine, it is true, values may be largely shared – a heart attack, for example, is, in and of itself, a bad condition for anyone (albeit that it may have good or bad consequences). In the early days of bioethics, then, when, as we described in the previous section, the focus of concern was very much on high-tech medicine, shared values could be assumed. There were clear abuses of biomedical technology to be tackled, i.e. uses of such technology that were abusive by (almost) everyone's values, as in Nazi concentration camps, for example (Chodoff, 1999), and the notorious Tuskegee incident (in which patients with syphilis were left untreated without their knowledge). But such cases are the exception rather than the rule. In healthcare practice as a whole the rule is diversity, not uniformity, of values. Disability itself, as Sally French and John Swain's study in chapter 78 shows, may be a matter of positive rather than negative value. Where there is diversity of values, then, the bioethicist as advocate, in throwing down the traditional idol of "doctor knows best," is at risk of setting up a new idol of "ethicist knows best."

Diversity of values is the core message of this book. Diversity of values, though, as the range of our readings illustrates, means diversity not just among patients and carers but also among professionals. In this respect healthcare ethics generalizes the original bioethical principle of respect for patients' values. It starts from a recognition of the diversity of human values operative in healthcare not only among patients but among patients and professionals alike.

Where one goes in practice with this generalization of the principle of autonomy is a further question. Basing healthcare ethics on a recognition of diversity of values (the values of professionals as well as patients) opens up crucial issues of methodology (of how ethical reasoning should be employed) and of practical application. We

return to these issues below. First, though, we will consider the implications of the shift in aims from a quasi-legal to a healthcare model for the scope of application of bioethics.

Scope of Application

The origins of bioethics, as a response to the challenges of biomedical science, are evident not only in its aims but also in its scope of application, viz., the areas of healthcare, and the kinds of clinical problem, with which it is concerned. It is in its scope of application, indeed, that bioethics' origins in biotechnology are most transparently evident. For bioethics has been concerned, primarily, with ethical problems in high-tech areas of secondary care, and with these problems as they arise mainly in relation to the applications of biomedical science in treatment. Healthcare ethics, by contrast, is concerned as much with primary as with secondary care; and with ethical issues as they arise not only in treatment but at all stages of the clinical encounter, including diagnosis. Both aspects of the wider scope of healthcare ethics are reflected in this volume.

From secondary to primary care

As noted above, dramatic advances in biotechnological science in the second half of the twentieth century created a raft of new ethical problems in healthcare. These problems have a high "gee-whiz" factor: heart transplants, brain implants, human cloning, cancer cures, fetal selection, genetic medicine, are all, rightly, headline-grabbing developments which challenge our deepest ethical intuitions about ourselves and the world in which we live. Small wonder, then, that the issues they raise have been and to a large extent remain at the top of bioethics' agenda.

Yet the high gee-whiz factor of these developments is out of all proportion to their significance, ethically speaking, in day-to-day healthcare practice. There is no sharp divide here, of course. Our readings, indeed, include problems in secondary as well as primary care. But we have sought to redress the balance. Thus

we have included no discussion of genetic selection of embryos, important as the ethical issues raised by this prospect may be. Instead, we cover the day-to-day experience of the implications of fetal screening (Julian Savulescu's "Letter from a doctor as a dad") and of the stigmatization of the new genetic underclass (ch. 11). Add to such issues, then, wider endemic problems such as poverty of resources (see Hope et al., this volume, ch. 26), and it becomes clear that, although they are less high profile, the ethical issues of primary care are far more significant practically than those of secondary care.

From treatment to all stages of the clinical encounter, including diagnosis

Neither the origins of bioethics as a response to the challenges of biomedicine nor its self-set aims of regulation and advocacy sufficiently explain its particular focus on treatment. "Treatment," in this context, should be broadly construed as covering any aspect of how a problem is dealt with: thus, besides direct interventions with drugs, surgery, and so forth, we use the term to cover prevention, screening, resource issues, and participation in research. All these come high on the bioethical agenda. But they have occupied bioethics largely to the exclusion of issues arising from how the problem itself is understood in the first place, namely, issues arising in the clinical encounter from diagnosis, aetiology (attribution of causes), and prognosis (prediction of outcome).

The focus in much of bioethics on treatment, we suggest, reflects the fact that, as is often the way with strong campaigners, it has unwittingly taken on the colours of its enemy. The enemy, then, metaphorically, is biomedicine: and the colours of the enemy are the elements of what has become widely known as the medical model. The medical model is biomedicine's underlying conceptual framework. It has been represented in various ways (see Macklin, 1973, and Fulford, 1998, for reviews). But it is essentially a medical *scientific* model. According to this model, medical *theory*, as the American philosopher Christopher Boorse put it, "is continuous with theory in biology and the other natural

sciences" (1975: 55). Correspondingly, then, it is only when science is applied in medical *practice* that values (and hence ethical issues) come into the frame. Again, views differ as to exactly where the boundary between value-free theory and value-laden practice should be drawn (Fulford, 2001). But the broad consensus within the medical model is that the disease concepts on which medical diagnosis is based are value-free scientific concepts.

The medical model is plausible in high-tech secondary medicine. Here, it seems, diagnosis – coming to an understanding of the problem – is based simply on gathering facts: we take “a history,” carry out a “physical examination,” and organize laboratory tests. Even here, it should be said, the *process* of diagnosis may raise ethical issues. These, as Humphrey et al.’s work on venepuncture in children (ch. 21), and Solomon et al.’s study of endoscopy in the elderly (ch. 54) both show, may not be self-evident: procedures which appear trivial from the point of view of the professional may be highly problematic from that of the patient. All the same, the major ethical issues, on this model, arise not from diagnosis but from treatment. How the problem is understood, and hence the options available for doing something about it, are (according to the medical model) a matter for medical science. It is only when it comes to choosing between these options that the values of those concerned become relevant. Or, to put the point in terms of autonomy, the medical model allows patients to have a say in how their problems are treated, but it gives them no say at all in how their problems are understood in the first place.³

The medical model is considerably less plausible in primary care, however. In primary care, what is a problem for one person – an ache or pain, being a certain weight, having a given level of energy, or a particular sleep pattern – may not be a problem for another person. The facts are the same; it is how the facts are evaluated (good, bad, or indifferent) that varies. In psychiatry, as the case history of Simon (ch. 20) illustrates, the relevant value judgments (although not widely recognized for what they are) are actually explicit in the diagnostic criteria to be found in medical-scientific classifications such as the American DSM-IV (the

Diagnostic and Statistical Manual; American Psychiatric Association, 1994; see also Jackson and Fulford, 1997; and Fulford, 1994a). Medical diagnosis, we should add, is a matter not just of negative evaluation but of a particular *kind* of negative evaluation: disease has to be distinguished from other bad or unwelcome states (such as ugliness, foolishness, wickedness, etc.⁴). But in primary care, it seems, diagnosis is at least in part a matter of negative values.

If values are important in diagnosis, then, at the heart of the medical scientific model, values are likely to be important at all stages of the clinical encounter. With values, moreover, in a sense the very antithesis of scientific facts, will go a whole series of further “unscientific” but humanistically important elements of medicine – meaning, significance, understanding, empathy, responsibility, intuition, subjectivity, and an individual perspective. All this implies a theoretical model for healthcare ethics which is very different from the traditional medical model.

Conceptual Models of Medicine: From a Fact-based (Medical) Model to a Fact + Value-based (Healthcare) Model

There are a number of possible ways of interpreting the more value-laden nature of primary care, depending on how one understands the nature of medicine itself. Thus, according to the medical model, primary care is more value-laden because it is less scientific. Psychiatry, in particular, has been thought to be value-laden for this reason. Boorse, whose influential work we noted a moment ago, takes this line. He argues that psychiatry’s continuing tendency (its disavowals notwithstanding) to make “social value judgments a test of normality” (1977: 380) stems from the absence of a “deep (biological) theory of psychological part function” (ibid: 382) which “takes physiology as a *model*” (ibid: 376; emphasis in original). Even some of psychiatry’s friends have implicitly adopted a denigratory view of medical psychiatry (Phillips, 2000). Among anti-psychiatrists,

Thomas Szasz (1960) takes the more value-laden nature of psychiatric diagnosis to show that mental disorders are not really medical diseases at all but moral problems. In the popular imagination, similarly, the scientific cutting edge is perceived as being in secondary rather than primary care, epitomized by the technological wizardries of gene-sequencing, brain scanners, and the like.

A number of bioethicists, too, reflecting their implicit adoption of the medical model, have taken a similar line. Tom Beauchamp and James Childress, for example, to whose "principles" we return below, are unusual among bioethicists in offering a detailed analysis of how the concept of mental disorder underpins the ethics of involuntary psychiatric treatment. They connect the justification for such treatment, of a fully conscious adult patient of normal intelligence, to impaired capacity for autonomous choice; they analyze autonomy in terms of rationality; and they show that judgments of rationality are, in part, *value* judgments. But instead of concluding that value judgments are therefore integral to psychiatric diagnosis, they conclude that balancing autonomy with beneficence is a "moral *not a medical* problem" (Beauchamp and Childress, 1994: 84; emphasis added).

On this view, then, the values operative in diagnosis in primary but not (apparently) in secondary care are provisional on future developments in medical science. When medical science has developed sufficiently, therefore, there will be no need for healthcare ethics. There will be no need, indeed, for a book of this kind!

A different, indeed contrary, interpretation of the more value-laden nature of primary care is suggested by work in what is sometimes rather grandly called philosophical value theory, i.e., that part of ethical theory which is concerned with the logical properties – the meanings and implications – of value terms. Although not currently high profile in bioethics, nor indeed in ethics generally, philosophical value theory was the focus of a considerable research effort among analytic philosophers, notably in Oxford, in the middle decades of the twentieth century. Work from that period is highly relevant to our

understanding of the relationship between fact and value (or, more precisely, descriptive and evaluative meaning) in the language of medicine.

We do not have space, here, to describe this work in detail. One of us has attempted this elsewhere (Fulford, 1989; and, in outline, Fulford and Bloch, 2000). The key point, though, for our present purposes is an observation, made most directly by a former Professor of Moral Philosophy in Oxford, R. M. Hare (see, e.g., Hare, 1952; and 1963), that value terms may come to look like factual terms where the value judgments they express are widely settled or agreed upon. Thus, "good" in "good eating apple," although expressing the value judgment "this apple is good to eat," carries the factual meaning "clean-skinned, sweet, grub-free, etc." This is because, straightforwardly, for most people in most contexts a clean-skinned, sweet, grub-free apple is a good eating apple. Hence this factual meaning has become stuck by association to the use of the value term "good" in respect of eating apples. Whereas, by contrast, "good" used of pictures, in respect of which people's values are highly diverse, has no consistent factual associations, and it thus remains overtly evaluative in meaning.

Hare's work on the way value judgments can come to look like descriptive or factual statements can be mapped directly onto the difference in evaluative connotations between primary and secondary care. According to the medical model, as we have seen, primary care is more value-laden because, essentially, it is scientifically primitive compared with secondary care. Hare's work suggests, to the contrary, that primary care is more value-laden, not because it is scientifically primitive compared with secondary care, but because it is *ethically more complex*.

It will be worth unpacking this suggestion a little, since it is the key both to the way in which ethical reasoning is employed in healthcare ethics and to its practical applications (to both of which we return in a moment). Thus, Hare's work suggests that secondary care is less value-laden not because it is more scientific, but because (as with "good" used of apples) the values operative in this area of healthcare are

widely settled or agreed upon. We have already seen that this is broadly true at least of major pathology – a heart attack, as noted above, is in itself a *bad* condition for most people in most contexts. Hence, in respect of such conditions, because the relevant values are the same from person to person, there will rarely, if ever, be disagreements about them. Hence, such values can be ignored for practical purposes. Hence secondary care is, to this extent, uncomplicated ethically (to the extent that the relevant human values are shared). Conversely, then, Hare's work suggests that primary care is *more* value-laden, not because it is *less* scientific, but because (as with "good" used of pictures) the relevant human values are *highly diverse*. Hence in primary care the values (as well as the facts) *cannot* be ignored for practical purposes. Hence primary care is, to this extent, more *complex* ethically than secondary care.

The readings included in this book speak volumes to the diversity of human values operative in healthcare. Indeed, if there is a single message that we hope the book will convey, it is that these values are far more diverse than any of us, from our individual or professional perspectives, normally recognize. Raising our awareness of this given diversity of values, as we will indicate in the next two sections of this Introduction, is the first step to developing a practically effective healthcare ethics.

Two final points, though, need to be made before ending this section. The first is that primary care, in being more overtly value-laden, offers a window on secondary care. This, too, is clear from the chapters in this book. For while it is true that there are some areas of secondary care (like heart attacks) where the relevant values are shared, the contributions to this volume show that diversity of values is not restricted to primary care. There is a spectrum, certainly; and along this spectrum, secondary care, in tackling major pathology with high-tech scientific tools, is more towards the "shared values" end. But shared values are the exception rather than the rule. Hence, diversity of values, although more obvious in primary care, is important in all areas of medicine. Healthcare ethics is thus an ethics for all areas of healthcare.

The second point is that scientific advance will increase, not (as the medical model suggests) decrease, the importance of diversity of human values in healthcare. This is because one effect of scientific advance is to expand the remit of high-tech medicine into areas in which human values are highly diverse (Fulford, 2000a). In genetic medicine, for example, as Ruth Chadwick's work shows (ch. 10), the options opened up by the identification of genetic markers for an ever wider range of characteristics are ones in respect of which different groups, and indeed different individuals, will have very different values.

Scientific advance, then, will not make books of this kind redundant. Scientific advance itself will see to it that diversity of human values will become more, not less, important in all areas of healthcare in the years to come. But quasi-legal ethics, we argued earlier, was a response to the challenges of scientific advances in medicine. How, then, will healthcare ethics (as defined in this book) respond to these challenges? How will it differ from quasi-legal ethics in ethical reasoning? How will it differ from quasi-legal ethics in practical applications?

Ethical Reasoning

Quasi-legal ethics employs ethical reasoning substantively, that is, to draw ethical conclusions. This is consistent with both its aims and scope. If your aim is to regulate, you must have decided what people ought to do. If your aim is to advocate, you must have decided what it is you want to advocate. Regulation and advocacy, then, both depend on (or at any rate assume) shared values. And in secondary care, as we have seen, in particular as it involves high-tech treatments for major pathology, values are indeed (relatively) shared.

Healthcare ethics, by contrast, in starting from diversity of values, differs radically from quasi-legal ethics in the use it makes of ethical reasoning, in being, at one and the same time, both more abstract and more concrete. It is more abstract in its use of ethical theory; it is more concrete in the extent to which it relies on the results of empirical studies.

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Ethical theory: from substantive to analytic

The difference between bioethics and healthcare ethics in ethical reasoning is well illustrated by their two very different ways of using principles (we consider other forms of ethical reasoning below). A classic account of the use of principles in ethical reasoning in medicine is a book we mentioned earlier, Beauchamp and Childress's *Principles of Biomedical Ethics* (1994). This employs four ethical principles important in healthcare – autonomy, beneficence, non-maleficence, and justice. As we noted earlier, in their exclusion of values from diagnosis Beauchamp and Childress identify, implicitly, with the medical model. Their use of principles, though, perhaps somewhat surprisingly, is closer to (abstract) healthcare ethics than to (substantive) quasi-legal ethics.

Thus, one way to understand the use of principles in ethics is as a problem-solving algorithm: you feed in the problem, adjust the principles, and out comes the answer. This algorithmic approach is similar to legal reasoning, at least where this is based on rules (explicit legal principles or statutes) as distinct from case law. As a method of ethical reasoning, however, the algorithmic approach has been rightly criticized for being too mechanical. It is said to be too insensitive to the nuanced subtleties of the particular situations in which real-life ethical problems arise. Principles need not be used insensitively, of course; but there is certainly this danger. And the approach is anyway subject to a deeper methodological criticism, that "adjusting the principles," as we put it, the crucial weighing of principle against principle, has to be done intuitively. In other words, the key step in the algorithm is not algorithmically defined. In its own terms, therefore, the approach (understood in this way) fails.

Beauchamp and Childress (1994) has been criticized on both these algorithmic counts (Culver and Gert, 1982). "Principlism," indeed, has become a dirty word among many in bioethics! Yet what Beauchamp and Childress actually *say* about the use of principles in ethical reasoning in medicine is quite different. They emphasize (e.g. in their chapter 1) that principles reasoning, far from being used mechanically, as an algorithm,

must be carefully contextualized. This indeed follows directly from the very nature of principles, as Beauchamp and Childress define them. Their principles are *prima facie*: that is, they are principles that are *likely* to be relevant in some degree to any given ethical problem in practice; and their role, therefore, is to provide a *framework* for ethical reasoning rather than, in themselves, to generate ethical conclusions. Understood as a framework, therefore, the use of principles in ethical reasoning cannot be separated from a careful consideration of the concrete details of a given case; and the required intuitive weighing of principle against principle cannot be separated from the particular circumstances of that case.

In healthcare ethics, then, we should understand principles reasoning not as generating ethical conclusions directly, but rather as providing a four-dimensional "ethical space" in which the relevant particulars of a given situation can be mapped out. This is the sense in which principles reasoning in healthcare ethics is abstract rather than substantive. It provides a way of analyzing ethical problems, a framework for ethical reasoning, rather than a mechanism for producing ethical answers as such.

Mark you, understood in this way, principles reasoning is far from being empty practically. In the first place, just in mapping out the space of values it may reveal aspects of the situation that are not immediately self-evident; and some ethical "problems" consist in simple failures fully to appreciate all aspects of the situation in question (the focus, say, has been on autonomy at the expense of issues of justice). Mapping out the "ethical space," then, may in itself help to resolve the problem. At the very least, it will help to clarify the problem. This in turn may point the way to a solution: perhaps more information is needed, for example; or a deeper analysis of an underlying concept (as in Beauchamp and Childress's analysis of rationality noted above). And then, yes, if there is no solution, an intuitive weighing of values may in the end be necessary. Necessary because, in practice, matters cannot be left in the air. In practice, something has to be done (even if the "something" is just to leave well alone – see Fulford, 1994b). The problem, that is to say, if not solvable, still has to be

resolved. Call the principles *values*, furthermore, and there is nothing in itself suspect about weighing them intuitively. How else, after all, can we *resolve* value issues? The alternative, certainly, is to impose a solution from a given value perspective. But this takes us back to the "rules and regulation" approach of quasi-legal ethics, which, as we have seen, although acceptable in situations in which values are shared, is inappropriate where values are not shared, where, as in primary (and increasingly in secondary) care, the relevant values are highly diverse.

Principles reasoning, then, as advocated by Beauchamp and Childress, is not an algorithm for producing ethical answers. It is one way of exploring the values which, although not always self-evident, are operative in a given situation. It helps us to map out the space of values. This may sometimes show the way to a solution (directly or indirectly); but it does not in itself produce solutions. To the contrary, it leaves resolution, in the contingencies of real clinical decision-making, firmly in the hands of those concerned. For the intuitive weighing of values to which principles reasoning points is, in the end, a matter for individual (value) judgment. This is why, as we noted a moment ago, principles reasoning in healthcare ethics is abstract rather than substantive. Principles reasoning contributes to clinical decision-making by giving us a thinking skill, a way of exploring and responding to ethical problems in practice, rather than by producing answers.

The importance of this distinction – between abstract and substantive, between improving thinking skills and handing down answers – in situations of value diversity is even clearer for one of the main rivals to principles reasoning, casuistry. Casuistry differs from principles reasoning in being bottom up (starting from particular cases) rather than top down (starting from general principles). It was introduced into bioethics by Albert Jonsen and Stephen Toulmin, in their ground-breaking book *The Abuse of Casuistry* (1988), as a way of producing answers. Jonsen was a philosopher and theologian and a member of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (in the USA). Toulmin, a philosopher, was on the Commis-

sion's professional staff. Both were struck by the fact that members of the Commission often agreed about *what* ought to be done in particular cases even though they disagreed widely about *why* it should be done. Hence, they argued, drawing on a deep vein of ethical theory, we should leave aside high level principles (concerned with reasons why) and focus on the contingencies of particular cases.

Casuistry is a powerful thinking skill for clinical decision-making. Understood substantively, though, as a way of producing answers to ethical problems, casuistry (like principles reasoning) depends on those concerned having shared values. It thus works well if the parties concerned are representative of those whose fate is under consideration. This is why the members of the National Commission, in Jonsen and Toulmin's original observation, agreed on what ought to be done. They differed in their political, religious, and ideological identifications; but their underlying values when it came to the ethical issues raised by biomedical advances were, nonetheless, the same.

The corollary, however, is that where those concerned are not representative, where their underlying values are not shared, casuistry can only produce answers if the values of the majority, or perhaps of a dominant minority, prevail. As the American philosopher, Loretta Kopelman, has pointed out, this may have adverse, even abusive, effects if the values operative in a given situation are left implicit rather than being made explicit in the casuistic process (Kopelman, 1994). Casuistry is not unique in this respect, of course. Hidden values (political in this case) lay behind the abusive uses of psychiatric diagnostic categories in the former USSR (Fulford et al., 1993). But the very strength of casuistry – its appeal to ethical intuitions rather than to explicit principles – puts it at perhaps particular risk of misuse in situations of value diversity (like primary care) if its basis in shared values is forgotten.

We do not wish to be misunderstood here. Casuistry is a powerful method of ethical reasoning. It is indeed particularly powerful in the context of clinical care. Being case-based, it is closely geared to clinical thinking; it is adaptable to the background and experiences of

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different clinical specialties, and indeed individuals; and it draws directly on the intuitive or craft knowledge by which professional expertise is (in part) characterized (Fulford and Bloch, 2000). In healthcare ethics, though, in situations of value diversity, its role may be as much to identify and characterize differences of values as to produce answers. Like principles reasoning, then, casuistry helps us to map out the "space of values" in a given case; as a form of ethical reasoning, this may contribute to clinical problem-solving in many ways (as above); principles and casuistry, indeed, in this respect may be highly complementary, notably in that most value-diverse area of primary care, psychiatry (Fulford and Hope, 1993); but neither form of ethical reasoning, as such, can produce ethical answers direct except where the values of those concerned are already shared.

Other more abstract forms of ethical reasoning can also be understood in this way, i.e., as contributing, in situations of value diversity, to the thinking skills of clinical problem-solving rather than producing answers to ethical problems as such: utilitarianism (consequences-driven) and deontology (rights-driven), for example; and virtue ethics (important especially in healthcare education – see Murray, 1994). Even more abstract, linguistic analysis, though relatively neglected in current philosophy, offers a powerful tool for unearthing hidden values in psychiatric diagnosis (Fulford, forthcoming), for example, and in our assumptions about clinical care (Peter Allmark, this volume, ch. 7).

Empirical studies: from informative to substantive

Abstract ethics has been criticized for eschewing substantive conclusions. Philosophical value theory, in particular, has been stigmatized as being trivial for this reason (Williams, 1985). Yet *all* theory is empty practically until it is combined with content. Theory is never productive in itself. That is why it is *theory*. The theory/content distinction (and its variants: form/content, analytic/synthetic, concept/data, etc.) is not without its philosophical critics (following Quine, 1948). But by analogy with mathematics in the natural sciences, ethical

theory, in providing thinking skills for clinical decision-making in healthcare ethics, must be combined with content if it is to have practical effect. Peter Allmark's critique of the "ethics of care" (ch. 7) makes this point directly. Care, as a framing concept, is ethically neutral: it is, as he points out, what we care *about* and *how* we care that make caring ethical or unethical.

There is much by way of content that may be relevant in a given case. The particular kind of content, though, relevant to ethical aspects of clinical problem-solving is human values. A key aim of this volume, as we have several times emphasized, is to illustrate the diversity of human values operative at all stages of the clinical encounter. Of the three kinds of reading included, the first-hand narratives are the most obviously relevant in this respect. Such narratives, as Howard Brody (ch. 19) was among the first to point out, in speaking directly to experience rarely fall short of achieving considerable dramatic impact. Elizabeth Forsythe's account of her husband's dementia, for example, presented here in two stages, his chronic illness (ch. 72) and subsequent death (ch. 86), is evocative in ways that no amount of secondary literature could achieve. But the work of novelists, too, may be deeply insightful, as in Tolstoy's account of the death of Ivan Illich (ch. 88). Poetry has a particular power of expressing ambiguous and implicit meanings (Kreitman, 1999). We have included a number of poems in this collection; Jenny Lewis's series of poems describing her experience of breast cancer provides a strong linking theme, introducing Parts II–IX of the book, and tracking the stages of the clinical encounter.

An important general point illustrated by these literary sources is the extent to which we fail to recognize just how different other people's values may be from our own. We noted a moment ago the dangers of unrecognized or hidden values. Hidden (or unacknowledged) values are particularly significant, though, in healthcare practice, in their effects on the relationships both between different professional groups and between professionals and their clients. Peter Campbell (ch. 56), for example, sets out, simply and directly, the oft-repeated but still not sufficiently heard view of the users

of psychiatric services, that their values are all too often eclipsed by those of service providers.

First-hand accounts, therefore, can help to raise awareness of the actual – rather than imagined – values operative in the clinical encounter. Systematic methods may also be important here. Indeed, such methods, in providing general information, importantly complement the particular perspectives of first-hand narratives. There is no shortage of such methods. We illustrate in this volume, *inter alia*, surveys (e.g. Snowdon et al.'s study of the effects on parents of their babies being "randomized" in a research trial in chapter 45), direct clinical observations (Terence Ryan and Vineel Kaur's work with people with disfiguring skin diseases in chapter 69), ethnographic methods (Steve Ersser's study of differences between nurses and patients in their respective understandings of caring in chapter 49), and direct experimental designs (Veronica Thomas's work on patient-controlled analgesia in chapter 43).

Just why people should be obtuse about each other's values is a further question. As far as professionals are concerned, being value-purblind can be an effect of a dominant professional model: the medical model, as noted above, prioritizes facts; hence, doctors have tended to focus on impersonal facts about their patients' problems rather than seeking to understand what is important about them from their individual perspectives. Our obtuseness, though, is also a product of our values not being fully transparent even to ourselves. Besides explicit methods, then, deeper analytic forms of inquiry may be helpful: phenomenological philosophy (Kay Toombs's phenomenology of her own experience of multiple sclerosis in chapter 3); John McMillan and Grant Gillett's postmodern and discursive ethics (ch. 37); hermeneutic methods (three varieties of which are described by Guy Widdershoven in chapter 4 and illustrated in his account with Wies Weijts of diagnostic styles in clinical relationships in chapter 25); Tod Chambers's use of the techniques of literary analysis (ch. 8); and psychoanalytic insights (Joan Raphael-Leff's work on the hidden emotions driving the experiences of both donor and recipient in assisted reproduction – see chapter 31).

An exciting recent development is the emergence of research paradigms combining philosophical-analytic and empirical methods. The rationale for this is the recognition that many of the problems with which we are concerned, in both clinical work and research, particularly in primary healthcare, are in part conceptual in nature.⁵ Thus the Canadian social scientist (who subsequently trained as a doctor), David Robertson, in a ground-breaking combined methods study, explored the ethical concepts implicit in the day-to-day work of an old-age psychiatry unit in Oxford (Robertson, 1996). In psychiatry, generally, analytic philosophy is a powerful ally of empirical methods derived from the social sciences in the study of implicit models of disorder (Colombo, 1997; Fulford, forthcoming). Continental philosophy, too, is a potentially rich resource for combined methods studies. The British psychiatrist, Pat Bracken (1995), for example, has employed both Foucault's philosophy in developing a novel user-guided approach to community mental healthcare and Heidegger's phenomenology as the basis of more effective methods for the management of trauma in non-western countries (Bracken, forthcoming).

There is no shortage of content, then, for a healthcare ethics in which ethical theory is employed not in itself to draw substantive conclusions, but as a key thinking skill in clinical problem-solving. Take away, though, the rules and regulations of traditional bioethics, and how does all this work out in practice?

Practical Applications

In this section, we outline some of the practical implications of healthcare ethics, respectively, for ethics itself, for law, and for communication skills. As with our earlier points, these three aspects of healthcare ethics should be understood as a series of shifts of emphasis within bioethics, aimed not at dispensing with quasi-legal ethics, but at providing a more balanced approach.

The three shifts of emphasis are: (i) from rules to process in ethical thinking in healthcare; (ii) from external regulation to self-regulation as the basis of law; and (iii) from what might be called

an executive to a substantive role for communication skills in ethical problem-solving.

Ethics: from rules to process

As we noted at the beginning of this Introduction, it was natural that in the early stages of its development, bioethics should have adopted a regulatory stance, defining and progressively refining the rules of engagement between healthcare professionals and their clients and patients. It is important to recognize, however, that the demand for rules and regulations has come from professionals no less than from patients. This, too, is natural enough. It is professionals, no less than patients, who are faced, daily, with ethically bewildering clinical dilemmas. It is professionals, therefore, no less than their patients, who feel the need for rules, externally validated and binding on them and their patients alike, to guide their choices. It is professionals, no less than their patients, who in cases of doubt or difficulty want to be able to turn the problem over to a regulatory body with powers of disposal, relieving them of responsibility for interpreting the rules.

All this is natural enough. But is it appropriate? At a recent conference in England, for example, on confidentiality and mental health, the call – from patients and healthcare professionals alike – was for more detailed guidance (Stern, 2001). Yet the problems they faced, as reflected in a book based in part on the conference (Cordess, 2001), were in large part themselves a direct result of the growing volume of ethical codes and legal regulation bearing on issues of confidentiality in healthcare. Contributor after contributor to Cordess's book, from psychiatry, social work, the law and so forth, called for further rules and regulations. But the problems they described arose from the rules themselves. The rules were now so all-embracing, they demanded such extreme standards, that they had become in some cases not only impractical but inimical to good practice. In multidisciplinary teamwork, for example, the relevant codes precluded sharing of information between agencies: but good practice in community care depends on just such sharing (Szmukler and Holloway, 2001). The result, in many cases,

was that practitioners had started to vote with their feet, honoring the codes more in the breach than in the observance (Pritchard, 2001).

This paradox, however, of ethical rules and regulations themselves becoming part of the problem is readily resolved once the diversity of values operative in healthcare is recognized. As one of us has argued elsewhere (Fulford, 2001), rules and regulations work well where values are shared. To the extent that values are shared, rules and regulations may indeed be a powerful mechanism for promoting ethical practice: they are a protection, notably, for healthcare practitioners working in abusive political regimes. Where values are *not* shared, however, rules and regulations, if they are intended to be substantive in effect, will necessarily be incompatible with the values of many of those to whom they apply.

We want to be clear about this. Rules and regulations have an important place. The point is that there is a great deal in ethics that cannot be done with rules and regulations alone. And ratcheting up the rules and regulations bearing on healthcare, although important in the early days of bioethics, shows signs, as we described in the first section of this Introduction (on Aims), of having reached the point of diminishing returns. It may be time to ratchet back, therefore. It may be time to stop producing ever more detailed substantive rules, expressing particular values. It may be time to balance up the rules and regulation approach with a model of ethics that aims to secure processes of clinical decision-making that respect, and as far as possible respond to, the diversity of human values operative in the particular circumstances of individual choices.

What a shift from rules to process will mean in practice is a large question to which, we believe, insufficient attention has been paid (Fulford, 2001). It will certainly involve an enlarged role for communication skills, to which we return in a moment. It will also require a shift in the relationship between ethics and law.

Law: from external regulation to self-regulation

Hand-in-hand with the rise of quasi-legal bioethics has gone a shift in medical law from self-

regulation to external regulation of healthcare professionals. In the UK, this process has been fueled by a series of failures of self-regulation, particularly among doctors. The result of this has been that the principal self-regulatory body of the medical profession in England and Wales, the General Medical Council, is itself under threat.

A degree of external regulation is, of course, essential for any group in society. In healthcare, then, it is salutary, for example, that we have moved from a "doctor knows best" basis for clinical decision-making in the direction of "patient knows best." This has been reflected in medical law, in the UK, in a watering-down of what is known as the Bolam principle. The Bolam principle is the ultimate in professional self-regulation. It makes doctors themselves the measure of good standards of medical practice. More precisely, it defines good standards of medical practice as the standards to which any group of appropriately qualified practitioners subscribe. The Bolam principle, then, if not in theory inimical to patient autonomy (to which, after all, many practitioners subscribe), is perceived as being inimical to patient autonomy in practice (because the reference standard for good practice is professional-, not patient-, based). In the courts in the UK, in consequence, there has been a growing tendency to be guided not by what practitioners regard as right in a given situation (i.e. the Bolam principle), but by what the patient concerned wants (or would have wanted if appropriately informed).

But now the question arises, how far should this go? Will it be salutary if one extreme principle ("doctor knows best") ends up being replaced with another extreme principle ("patient knows best")? Would a consumer model of healthcare practice – interventions on demand (so long as you can pay for them) – be ethical? Clearly a balance is needed. But how, and on what basis, is the balance to be struck?

This is another large question to which we will not attempt a comprehensive answer. Self-regulation, though, albeit with an important twist on traditional models, has, we believe, a part to play. Again, the key is value diversity. But to see this we need to look in more detail at

the Bolam principle and its relationship to professional expertise. Thus, the Bolam principle in effect accommodates value diversity so far as the values of professionals are concerned. The principle allows for, indeed it directly incorporates, differences of professional opinion. The Bolam principle requires not uniformity, nor even a consensus view, but only that a *group* of relevant professionals support the action in question. Professional opinion, then, may vary. This is partly a matter of differences of view on matters of fact. And professional expertise, it is worth noting, is under attack on its factual side: "evidence-based" practice, and management-led approaches to developing clinical practice guidelines, are increasingly subordinating individual clinical judgment to consensus opinion. But professional judgment is also a matter of values. Opinion on the facts (on what, say, the effects of a given treatment will be) may be the same; but there may still be wide differences of professional opinion on questions of value (on whether the treatment in question will be, in a given case, to *good* effect).

The parallel with evidence-based practice might now suggest that external regulation is, after all, the way to better standards of care. The assumption behind evidence-based practice is that science – in the form of computer-based meta-analyses of selected high-quality scientific research – is capable of providing more accurate opinion than the vagaries of individual clinical opinion. It is certainly true that such meta-analyses may supply important findings. But this general information, pooled across hundreds of studies, has always to be applied, in the context of clinical decision-making, to particular cases. Work from a variety of disciplines suggests that moving from the general to the particular requires expertise which is, in part, incapable of being reduced to a set of explicit rules (Fulford, 2001). Rather like riding a bicycle, or recognizing a face, applying general knowledge to particular cases depends on skills to which "craft" or implicit knowledge is as important as the explicit knowledge which evidence-based practice supplies.

If this is true of the "fact" side of professional expertise, then, if even this cannot be fully captured by a set of explicit regulations, how

much more so will it be true of the value side? Here, though, comes the important twist to the self-regulation Bolam principle. For while the facts bearing on a given case may be a matter at least primarily for the professional (knowledge of causes, of available treatments, etc.), the relevant values are a matter as much for the patient as the professional. What is required, then, for a model of bioethics which starts from diversity of values, is not a return to "Bolam" per se. It is, rather, what one of us has called elsewhere "Bolam-plus" (Fulford, 2001). "Bolam-plus" is a framework of law that reflects not just diversity of professional opinion (Bolam), but diversity also of patients' values (Bolam-plus). Self-regulation, then, in healthcare ethics, aims to incorporate the values bearing on the decisions made together by individual professionals and patients within the contingencies of particular concrete clinical situations.

Communication skills: from an executive to a substantive role

Just how "Bolam plus" would work out in practice is yet another question to which we do not have a full answer. We should not be surprised to find open questions repeatedly cropping up like this in healthcare ethics. Open questions, rather than closed answers, are a feature of any subject at the cutting edge. One thing, though, is clear. Bolam-plus pushes the onus of decision back to those, patients and professionals, with the decisions to make. In contrast to the "calls for guidance" from both patients and professionals, noted at the start of this section, Bolam-plus is what a former professor of law in Oxford, H. L. A. Hart, called a "choosing system" (Hart, 1968). The function of law, Hart argued, is to provide a framework within which individual choices may be made as widely as possible and with a minimum of restrictions. "Bolam-plus" would thus be (part of) a choosing system for healthcare law. It would limit the role of law to providing a framework within which processes aimed at respecting diversity of values can operate to maximum effect. That such processes will depend crucially on good communication skills is self-evident. If diversity of values is to be respected, we must

at the very least understand the perspectives of those concerned. As the Oxford psychiatrist and Professor of Medical Ethics, Tony Hope, has pointed out, "perspectives," and our ability to understand and respect the often widely different perspectives of those concerned in clinical decision-making in healthcare, is a key component of the practice skills on which effective and ethically sound clinical decision-making critically depend (Hope et al., 1996).

Just how communication skills are taken to operate, however, depends on the model of bioethics adopted. In a quasi-legal model of bioethics, communication skills are, essentially, executive. They are required to give effect to ethical rules and regulations: to convey information, for example, as the basis of valid consent; to understand a given patient's wishes (out of respect for autonomy); or, in some cases, to "sell" a decision driven by a relevant ethical code, to someone who may disagree with it. On this quasi-legal model, then, the substantive ethical issues are determined by the rules. Communication skills are required only to execute the rules, to put them into effect.

In healthcare ethics, by contrast, ethical choices are determined, primarily, by the values of those concerned. Communication is central, therefore, where values are not shared. In such situations, rather than appealing to external rules and regulations, clinical decision-making depends on such communication skills as understanding each other's values, engaging in negotiation to agreed solutions, conflict resolution, and the like. In such situations, then, communication skills are the very essence of good clinical decision-making. It is in this sense that in healthcare ethics communication skills have a substantive rather than merely an executive role.

Conclusion: The Abuses of Absolutism

Mention diversity of values among traditionally minded doctors and the cry goes up "Relativism!" "Chaos!" Mention diversity of values among legally minded bioethicists and the cry goes up "Relativism!" "Chaos!" So is healthcare

ethics, as we have defined it in this Introduction, a basis for a more balanced contribution of ethics to medicine? Or is it a recipe for relativism and chaos?

Quasi-legal bioethics, combined with the medical model, holds out the prospect of an orderly approach to healthcare practice. In this model, as we noted earlier, ethics and science have well-defined roles. Science is responsible for the knowledge infrastructure of medicine: it defines diseases, discovers causes and cures, develops new technologies, and so forth. Ethics regulates the applications of scientific knowledge in practice; its role is to ensure that science and technology are employed in medicine in ways that promote the best interests of patients. Best interests, moreover, whatever the practical difficulties of deciding what is "best" in particular cases, is defined in principle by certain substantive values, such as autonomy. These values, incorporated into ethical codes, and supported by law, provide an agreed set of standards against which the performance of practitioners can (in principle) be objectively measured.

Healthcare ethics, as we have described, offers a radically different model: it aims for partnership rather than regulation; it is concerned with primary as well as secondary care; it is concerned with each stage of the clinical encounter (including diagnosis) rather than just, or primarily, with treatment; it draws more deeply on both abstract ethical theory and empirical findings; and in its applications to practice it emphasizes ethical process rather than ethical rules, self-regulation rather than regulation by external bodies, and a substantive rather than merely executive role for communication skills.

We summarized this list of differences in table I.1 at the beginning of this Introduction. As we noted there, extensive as the list is, it is nonetheless a list mainly of differences of emphasis rather than of kind: many of the features of healthcare ethics are reflected to a greater or lesser degree in developments in bioethics itself; and healthcare ethics, in the way we have defined it here, could thus be understood as little more than a consolidation and drawing to a head of an evolution already under way in bioethics.

The sticking point, though, for those concerned by relativism, is the diversity of values from which healthcare ethics starts and on which its differences from quasi-legal ethics are built up. Surely, the quasi-legal bioethicist will say, this invites partnership to degenerate into collusion. Surely, the medical-model doctor will say, it makes diagnosis (to which on a healthcare model, values are relevant) a matter of perspective (like taste in food or preferences in pictures). It is all very well, then, both will say, to talk of drawing deeply on abstract theory and empirical findings; but if a substantive system of ethical norms is replaced with diversity of values, ethical process will be left rudderless. For self-regulation, then, read self-interest; and for communication skills, read rhetoric. Healthcare ethics, therefore, if it is based on diversity of values, risks ethical meltdown.

Healthcare ethics, as we have several times emphasized, certainly does put the locus of ethical decision-making back where it belongs: with those at the clinical coalface, with patients and informal carers and with professionals. Healthcare ethics relocates the locus of ethical control from the rules and regulations of an external ethic to the values of those directly concerned in healthcare practice. This, many may feel, is no bad thing. Bioethics has in some areas already gone too far towards, as we put it earlier, a culture of "ethicist knows best." All the same, the values of those concerned, as this book seeks to illustrate, may be highly diverse. Hence healthcare ethics does indeed, and uncompromisingly, place diversity of values at the centre of the ethical action.

There is no ducking this conclusion. Diversity of human values is central. And in this our model of healthcare ethics, although indeed a natural extension of established trends in ethical thinking in medicine, does involve a qualitative shift from the absolutism of quasi-legal ethics to relativism. There is little risk of ethical chaos here, though, still less of ethical meltdown. There are two reasons for this. First, and straightforwardly, human values, if diverse, are certainly not chaotic. Human values, after all, permeate every aspect of our lives – law, aesthetics, sport, and, not least, as Charles Taylor's article so ably reminds us (ch. 9), science itself. Yet none of

these is chaotic. The second reason why there is no risk of ethical meltdown is because healthcare ethics, in showing the importance of values even in areas of medicine (like diagnosis) traditionally assumed to be "purely scientific," in no way undermines the importance of science. In so far as facts and values, description and evaluation, are separable, healthcare ethics conceives them as twin logical elements, woven together as warp and weft in the conceptual framework of healthcare as a whole.

Healthcare ethics, then, as one of us has put it elsewhere (Fulford and Bloch, 2000), adds values to, rather than subtracting facts from, medicine. All the same, it remains true that healthcare ethics, in being grounded in value diversity, precludes any a priori commitment to substantive values. In this sense it is, indeed, a relativistic rather than absolutist ethic. Yet this, in healthcare, is a strength not a weakness. For the hard lesson of history is that in medicine it is from absolutism, scientific as well as ethical, rather than from relativism that abusive practices have most often been born (Dickenson and Fulford, 2000: ch. 12). In the language of this book, the lesson of history is that abuses most often arise not from evil will, but from the spurious certainties of dogmatic conviction.

John Locke, the seventeenth-century political philosopher and philosopher of science, called such blind convictions "enthusiasms." In the twentieth century it was from the scientific enthusiasms generated by technological innovation that we had most to fear. Quasi-legal ethics, as we noted at the start of this introduction, was a proper response to these enthusiasms. In the twenty-first century, though, it is from the ethical enthusiasms driving quasi-legal thinking in bioethics that we have most to fear. This is because, as we described in the middle section of this introduction (Conceptual Models), technological advance itself is increasingly driving medicine as a whole into areas of human experience and behavior in which diversity of values is the norm.

NOTES

- 1 We are, of course, not the first to use the term "healthcare ethics." We adopt it here as reflecting

the importance of diversity of values in all areas of healthcare.

- 2 Also see Szmukler and Holloway (2001) on community psychiatry; and for a corresponding concern about disclosure, Bolla (2001) on psychoanalysis.
- 3 We owe this clear way of marking the distinction to Dr V. Y. Alison-Bolger (personal communication).
- 4 See generally, Fulford (1989), especially chs 6 and 7. Subsequent chapters of this book explore the ethical and conceptual significance of the particular kind of negative value expressed by the medical concepts in psychiatry. See also, for a more clinical account, Dickenson and Fulford (2000).
- 5 In principle, of course, all research, not least in the natural sciences, is in part conceptual in nature (Lakatos, 1974). The point is that in psychiatry, and in other areas of primary care, the problems we face are in practice as well as in principle in part conceptual in nature. They involve not just problems of fact but of how the facts should be interpreted or understood. Psychiatry has been widely stigmatized in this regard as being conceptually muddled. But this is to mistake conceptual difficulty for conceptual deficiency. Psychiatry is, indeed, conceptually difficult, perhaps more so than any other area in healthcare. But far from being a mark of deficiency, conceptual difficulty is the mark of a discipline (like theoretical physics) at the very cutting edge of understanding (see Fulford (2000b) for a more extended treatment of this point).

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