Values-Based Practice: A Theory-Practice Dynamic for Navigating Values and Difference in Health Care

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Abstract

This chapter introduces values-based practice as a resource for working with individually diverse values in health and social care, and describes its origins in an ongoing development through the resources of philosophy. The chapter is in two main sections. Section I, Values-Based Practice, builds on two brief interactive exercises to introduce and explain the key features of values-based practice. As a relatively recent addition to the range of resources for working with values in health and social care, values-based practice is distinctive in focussing on the diversity of values comprising individual lived experience. Like evidence-based practice, values-based practice is a process-driven rather than an outcome-driven methodology. That is to say, rather than offering prescribed answers, both approaches offer processes that support decision-makers in coming to answers for themselves based on the particular circumstances presented by the situation in question. Although entirely complementary, the processes involved are of course different. Where evidence-based practice relies on meta-analyses of the results of high-quality clinical trials to inform a consensual model of decision-making, values-based practice builds on learnable clinical skills and other process elements to inform a *dissensual* model of decision-making rather than seeking to overcome value-conflicts in reaching consensus. Working within a premise of mutual respect for differences of values, and guided by three key principles linking values and evidence, values-based practice, as described in the chapter, supports dissensual decision-making, balanced according to the circumstances presented by the decision in question, within frameworks of locally-set frameworks of shared values. Section II, The Theory-Practice Dynamic, then outlines the theory-practice dynamic on which values-based practice is based. The origins of values-based practice in mid-twentieth century ordinary language philosophy of the Oxford School are outlined. As the chapter illustrates, although a limited area of analytic philosophy, many aspects of values-based practice are informed by ordinary language philosophy, ranging from its premise, through the training exercises and other process elements described in Section I, to its role in hybrid empirical studies supporting its model of service delivery. The development of values-based practice, furthermore, as section II goes on to describe, is ongoing, with key initiatives drawing not only on both analytic and Continental traditions of European philosophy, but also on non-European philosophies such as those of Africa and the Caribbean.

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Introduction

Dancing with Angels[1]

Natalie (not her real name) was accompanied by angels. They used to sing to her and she to them. Natalie would often dance with her angels and though she caused no problems she was regularly taken to hospital and prescribed antipsychotic medication. Natalie refused to take medication because she believed that it killed her angels. In her mid-twenties she was detained on an involuntary basis and put on depot medication without her consent. Natalie subsequently took her own life. She left a note saying she couldn't face living without her angels.

Natalie's tragic story captures much that is important about values-based practice in health and social care. Below in this chapter we describe values-based practice in detail. But Natalie's story anticipates a number of key points about values and values-based practice that we should bear in mind throughout:

- Values as what matters to the individual person: health-related values include *anything that matters or is important to* those directly involved in a given situation; Natalie's voices mattered more to her than anything else in her life.
- Values beyond moral judgement: health-related values thus *include but are wider than ethical and legal values*; those concerned with Natalie's care genuinely thought they were doing 'right' by her and they used their powers of involuntary (i.e., compulsory) treatment entirely within the legal rules; yet, it was the failure to take seriously what mattered to Natalie that led in this story to tragedy.
- Health-related values *include centrally (but are not limited to) those of the service user concerned*; this is why the story makes a point of noting that Natalie's dancing with her angels caused no problems for other people. Had her voices been, for example, urging her to harm someone, the balance of values would have been less unequivocal.
- Health-related values require *a process for balanced decision-making* where values conflict: Natalie's story is very individual to her and (beyond the importance of the individual uniqueness of values) implies no general rule about voice hearing; as just

[1] Based on real events but with identifying details altered – from Crepaz-Keay and Fulford (2021).

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noted, had her angels told her to harm other people, her story would have been a different story requiring different decision-making.

- A process-based model of balanced decision-making is *provided by values-based practice*: it starts from a recognition of the diversity of individual values as they impact on health care (some people who hear voices want to get rid of them; Natalie's voices mattered so much to her that she couldn't live without them); and rather than seeking a rule defining pre-set 'right' outcomes, values-based practice relies on clinical skills and other process elements (described below) for balanced decision-making in the situation in question.
- As a decision-support tool, values-based practice is a *partner to evidence-based practice*: there is good evidence that a recovery-oriented person-centred approach to supporting Natalie with her voices would have had a positive outcome for everyone.

So described, values and values-based practice *raise a whole series of long-standing philosophical issues,* not least in the long-running 'is-ought'debate about the relationship between facts and values (or descriptive and evaluative meanings). This is why values-based practice remains a product of an ongoing theory-practice dynamic. Practical implementation is not contingent on the underlying theoretical issues being resolved. But engaging with these issues both enhances philosophical work in relevant areas while at the same time ensuring that values-based practice continues to develop as a research-led discipline rather than collapsing into pragmatically-driven received simplifications.

In this chapter, we will first describe values-based practice as it is used in contemporary health and social care, and then indicate a number of future developments arising from the continued operation of the theory-practice dynamic on which it is based.

Section I: Values-Based Practice

As a practical discipline, values-based practice is best understood by 'doing not saying', that is to say, being a skills-based approach it is most effectively learned through practical engagement with the issues rather than from merely reading about them. Hence, we will introduce it here with two of the interactive exercises we have developed for medical students and other healthcare workers as part of their training for front-line clinical and social care. We will describe these exercises and their usual outcomes so there is no need to do

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them for yourself. But they take only a few moments each, and you may find doing them for real illuminating.

Exercise 1: The Three Words Exercise[2]

Although based on the philosophical principles outlined below, the 'three words' exercise works as an exercise in word association.

> The exercise is simply to 'write down *three words* (or very short phrases) that *mean 'values' to you*.
>
> If you try this for yourself, take a few moments to actually write down your own 'three words' before reading on – in training exercises we find writing your answers down rather than just doing the exercise 'in your head' makes a big difference to learning (remember, this is about 'doing not saying'!).

Figure 1 (over page) shows the answers given in one of our training exercises – how did your three words compare with these? What strikes you about Figure 1?

There are two key learning points to take from this exercise:

> *1) The diversity of values* – this is reflected in the variety of triplets people come up with. There are repeat words, certainly ('principles', for example, and 'best interests') but even running this exercise with up to 200 students we have never yet had two respondents come up with exactly the same three words.

If you are not surprised by this perhaps you should be. After all, 'values' is not an unfamiliar word. In a sense we all know what it means. But when it comes to a challenge of this sort, it appears we all mean something slightly different by this term! On the other hand, once we identify 'values' as the non-technical and pre-reflective notion to simply mean 'what matters to you', the diversity of individual values should perhaps not come as a surprise.

In the next exercise we will see how the diversity of meanings we attach to the word 'values' is reflected in the diversity of the personal values that drive our choices in health and social care.

> *2) Values and 'what matters to you'* – if we look again at Figure 1, we notice something else – yes, everyone's triplet is different; but

[2] This exercise was devised originally by Kim Woodbridge, a nurse trainer at the Sainsbury Centre for Mental Health, who worked with Bill Fulford to develop the first training manual for values-based practice (see Woodbridge and Fulford, 2004).

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Preferences *Needs* *Best interests*	*How we treat people* *Attitudes* *Principles*
Respect *Personal to me* *Difference ... diversity*	*Non-violence* *Compassion* *Dialogue*
Beliefs *Right/wrong to me* *What I am*	*Responsibility* *Accountability* *Best interests*
Belief *Principles* *Things held dear*	*What I believe* *What makes me tick* *What I won't compromise*
Subjective merits *Meanings* *Person-centred care*	*'Objective' core* *Confidentiality* *Honesty*

Figure 1. A sample of the triplets of words given by participants in a training session in values-based practice.

there is nothing in the triplets of words people come up with that seems simply nothing to do with values.

So, we can think of the results of this exercise as picking out different aspects of what – despite the everyday familiarity of the word 'values' – is a complex multifaceted notion. We will return to this point in the second half of the chapter when we look at the theory underpinning

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values-based practice. For now, one way of drawing together these different meanings, is to say that for clinical purposes, 'values' include …

- anything that matters or is important to those concerned in the situation in question.

This (admittedly tautological) definition may perhaps be lacking philosophically in clarity and depth as much as in content. But it works well in clinical contexts to emphasise the breadth and diversity of relevant issues. It also provides a helpful nominal link between values-based practice and the growing international 'what matters to you?' movement, which as its name suggests, promotes the importance of finding out 'what matters to you?'.[3] The next exercise shows why this is significant, why it is that (as in values-based practice) clinical decision-making should be based on asking not only 'what is the matter *with* you?' but also 'what matters *to* you?'.

Exercise 2: A Forced Choice Exercise

Where the three words exercise is an exercise in word association, the 'forced choice' exercise requires an effort of the imagination.

> Imagine you have developed early symptoms of a potentially fatal disease.
> There are two possible evidence-based treatments available, both of which offer advantages but neither of which is perfect:
>
> - TREATMENT A – gives you a guaranteed period of remission but no cure
> - TREATMENT B – gives you a 50:50 chance of 'kill or cure'
>
> It's your decision – what is the *minimum* period of remission you would want from Treatment A to choose that treatment rather than choosing the 50:50 'kill or cure' option offered by Treatment B?
> Write down, 1) your minimum period, and then, 2) your reasons for choosing the period that you did.

Figure 2 illustrates the wide range of minimum figures people come up with when they do this exercise. This is nothing to do with differences in the evidence-base of the decision: everyone had *the same*

[3] See https://wmty.world. Many organisations have their own websites dedicated to WMTY – see for example, The Institute for Healthcare Improvement website at: https://www.ihi.org/Topics/WhatMatters/Pages/default.aspx.

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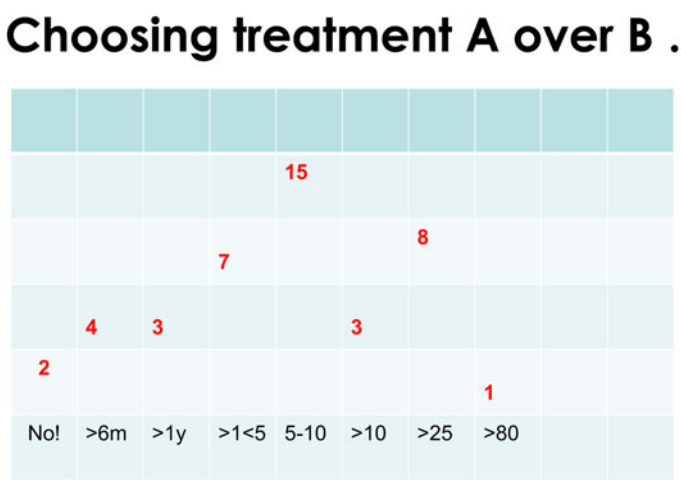

Figure 2. A typical range of responses in the forced choice exercise.

evidence base (an artificially constrained evidence base at that). Nor has it to do with diversity in the target group: the range of responses in Figure 1 happens to be from a group of medical students, roughly 50:50 men and women, though otherwise with similar backgrounds and ages; but we find a similar range is the norm with whatever group the exercise is used.

The second part of the exercise then shows us that we get this wide range because, despite their apparent similarities, individuals bring very different personal values to the choices they make. This is the message of the 'what matters to you?' movement – different things matter or are important to different people. In this exercise, one person may choose perhaps 20 years because he or she has a young family and wants enough time to see them safely grown up; another may choose only a year because that person is finishing a project that he or she feels passionate about and that will take a year to complete; and so on.

Again, if you did this exercise for real, revisit your minimum figure and the reasons behind it – what mattered or was important to you in this imaginary situation?

Learning Points from the Forced Choice Exercise

The key learning point from the forced choice exercise is the link between diversity of individual values and clinical decision-making. We can sum this up as:

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- *same evidence + different values = different decisions*

This in turn carries other important learning points:

- *The importance of shared decision-making based on evidence and values*

As clinicians we are familiar with the importance of the evidence-base for decision-making. The forced choice exercise reminds us that it is also important to take the values-base of decision making into account.

In the context of a training exercise this may seem obvious. That it is however far from obvious in practice is shown by the need for a whole international movement (noted above) pushing the importance of asking 'what matters to you?'. The need for such a movement, furthermore, continues despite growing emphasis on the importance in clinical care of shared decision-making – that is, decision-making that is shared between clinicians (as experts on the evidence) and patients (as experts on what matters to them) within contemporary models of patient-centred care. In the United Kingdom, for example, professional guidance for doctors has made shared decision-making of this kind the basis of consent to treatment for at least the last two decades (see General Medical Council, 2008). This guidance was reinforced by a decision of the UK Supreme Court in 2015 (the *Montgomery* ruling, Montgomery v Lanarkshire Health Board, 2015; see also, Herring *et al*., 2017), and it has been further reinforced by evidence-based guidelines from NICE, the UK's National Institute for Health and Care Excellence[4] (NICE, 2021).

So shared decision-making, it would seem, is harder than it appears. Once again, the forced choice exercise helps to explain why this should be so. We here draw attention to three salient considerations.

- *It is hard for patients*

One reason shared decision-making is difficult is that it is hard for patients. If you did the forced choice exercise for real you probably found it more challenging than exercise 1 (the 'three words' exercise). This is partly because the situation it asks you to imagine is not a pleasant one: though of course it is not unrealistic – it may indeed be a situation similar to one with which you have personal experience.

[4] NICE is responsible for providing evidence-based guidelines for the interventions that can and cannot be provided within the UK's National Health Service.

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But either way, the challenge most people find is to answer it *for yourself*. It is easy enough to say what 'most people' would choose as a minimum period; or what the 'rational choice' would be; but answering the question in the form of your own personal decision, taken for yourself as you are currently placed (at your own age and in your own situation), is, most people find, surprisingly challenging.

This is in itself an important learning point from the exercise – that answering the forced choice question (and its cognates) even in the relatively safe environment of a training session is surprisingly hard. How much harder therefore must it be for someone faced with this or an equivalent choice in circumstances of personal existential threat in choosing one's personal treatment outcome.

- *It is also hard for clinicians*

Understanding what matters to a given patient is also hard for clinicians. This is because as clinicians we are trained to understand 'what is the matter *with* you' and (wrongly) extrapolate this to understanding 'what matters *to* you'. This is well illustrated by the experience of Zoe Barber, one of the pathfinders for training in values-based practice in Oxford, of her first experience as a participant in the forced choice exercise. Mindful of her impending marriage and wish to start a family, Zoe chose twenty years as her minimum period; but was shocked when she found her partner, Tom, chose eighteen months. When he explained his reasoning (this was the time he needed to finish his PhD), she understood, but as she wrote later, it was a 'light bulb moment – If I could so misjudge the values of the man I share my life with, just how wrong might I be in assuming that I know what is important to the patient I met perhaps only five minutes ago!' (in Handa *et al.*, 2016, pp. 20–7).

- *Shared decision-making and recovery in person-centred mental health*

Shared decision-making is especially important in person-centred mental health care as the basis of recovery. 'Recovery' in this context means recovering a good quality of life as defined by the values of – by what matters or is important to – the person concerned (Slade *et al.*, 2014; Hughes *et al.*, 2018). This is challenging in several ways. First, as Natalie's story at the start of this chapter illustrates, recovery, so defined, may but in other cases it may not coincide with traditional professional concerns such as symptom control. It is challenging, second, because the operative values in a number of mental health conditions may present particular difficulties of understanding (we return to the philosophical resources supporting understanding in the second

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half of the chapter). It is challenging, third, because in mental health, what matters to the patient may be in conflict with what matters to everyone else (which is where the resources of values-based practice for balanced decision-making that we describe immediately below, come into play). But for all these challenges, without an understanding of what matters to the individual concerned, recovery in mental health cannot even get started.

The Process Elements of Values-Based Practice

We do not have space here to describe the process elements of values-based practice in detail (but see for example, Fulford, Peile and Carroll, 2015, and other Resources on the website for the Collaborating Centre for Values-based Practice in Oxford at: valuesbasedpractice.org).

The process of values-based practice is shown in the form of a summary flow diagram in Figure 3 and brief definitions of its constituent process elements are given in Figure 4. As these indicate, values-based practice is premised on mutual respect for differences of values. This does not mean that in values-based practice 'anything goes'; on the contrary, any form of racism or other discriminatory values are by definition excluded by the requirement for mutuality (we return to the philosophical origins of this premise in the second half of the chapter).

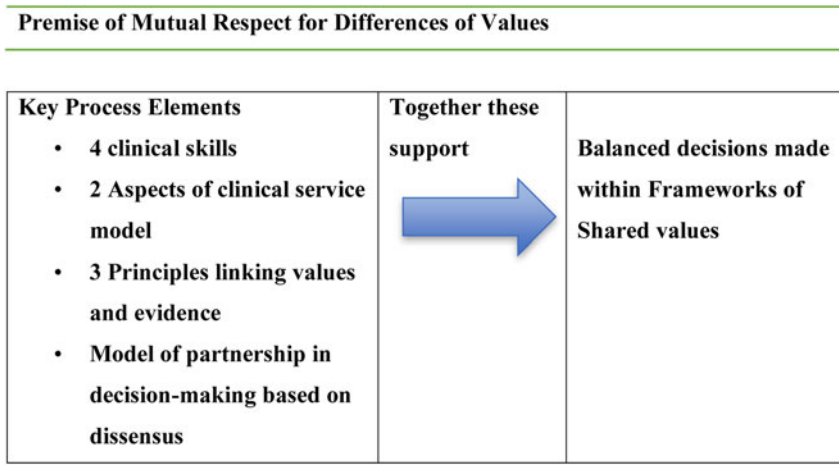

Figure 3. A Flow Diagram of Values-based Practice.

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Key Process Elements	Brief definitions
Premise of mutual respect	Mutual respect for differences of values
Learnable Clinical Skills	
Skills – awareness	Awareness of values and of differences of values
Skills – knowledge	Knowledge retrieval and its limitations
Skills – reasoning	Used to explore the values in play rather than to provide answers
Skills – communication	Especially for eliciting values and conflict resolution
Clinical Service Model	
Patient-*values*-centred care	Care centred on the actual rather than assumed values of the patient
***Extended* Multi-disciplinary Team**	MDT role extended to include a range of value perspectives (as well as of knowledge and skills) for interagency working
Relationship between Evidence and Values	
Two feet principle	All decisions are based on the two feet of values and evidence
Squeaky wheel principle	We notice values when they cause difficulties (like the squeaky wheel) but (like the wheel that doesn't squeak) they are always there and operative
Science-driven principle	Advances in medical science drive the need for VBP (as well as EBP) because they open up choices and with choices go values
Model of Decision-making	
Partnership	Decisions in VBP (although informed by clinical guidelines and other sources) are made by those directly concerned working together in partnership
Frameworks of shared values	Values shared by those in a given decision making context and within which balanced decisions can be made on individual cases
Balanced dissensual decision-making	Decisions in which the values in question remain in play to be balanced sometimes one way and sometimes in other ways according to the circumstances of a given case

Figure 4. Brief Definitions of the Process Elements of Values-Based Practice.

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Within the premise of mutual respect, values-based practice then builds on four key areas of learnable clinical skills (awareness, knowledge, reasoning, and communication) within a particular model of service delivery (one that is person-centred and multidisciplinary) and guided by three key principles linking evidence and values (namely, the Two Feet principle, the Squeaky Wheel principle, and the Science-Driven principle). Together, these support balanced decision-making on questions of values through a particular model of partnership (dissensual partnership) operating within (locally set) frameworks of shared values.

You will see how the above two exercises provide an introduction to values-based practice. In any actual training session, a focus on individual lived experience (as a service user or service provider) is of course essential. But with this caveat, the three words exercise sets the scene for training by making participants aware of the diversity of values. Hopefully, participants come to recognise for themselves that there is more to 'what matters to you?' than can be captured in ethical and legal guidelines. The forced choice exercise then builds on this, acting as a focus for discussion of almost any aspect of values-based practice. This is a guided discussion aimed at understanding the practical importance of shared decision-making based on values ('what matters to you?') as well as evidence (of what works in dealing with 'what's the matter with you').

Section II: The Theory-Practice Dynamic

The importance of ensuring that values-based practice remains driven by an ongoing dynamic between theory and practice received early endorsement from what at first glance might appear an unlikely source, namely a Senior Advisory Board of experienced clinicians, managers, and politicians, who generously took on the task of guiding the VBP Centre in Oxford through its early days of developing its impact within the UK health service.[5]

The background to this endorsement is worth brief reprise. Values-based practice was developed originally as a practical discipline mainly within mental health. As described further below, it was based originally on theoretical principles derived primarily from mid-twentieth century ordinary language analytic philosophy; but the philosophy as such had largely fallen out of view as the discipline started to take root in practice. For example, although the

[5] For details of our Founder Advisory Board, see https://valuesbasedpractice.org/who-are-we/advisory-board/.

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underlying philosophy had been instrumental in the development of a number of training exercises (see above), explicitly philosophical material was entirely absent from the first practical training manual for values-based practice (Woodbridge and Fulford, 2004).

It was perhaps understandable, therefore, that when we set up The Collaborating Centre in Oxford[6] with the aim of extending values-based practice from mental health to other areas of health care, our focus at the time should have been on practice rather than theory. At the first meeting of our Advisory Board, correspondingly, we described how rather than developing the theory of values-based practice, we had identified three key areas of practice on which we would focus – training, regulation, and teamwork. Yes, good thinking, our Advisory Board commented, drawing on their considerable experience; but not, they continued, if this is at the expense of theory. There should instead be an ongoing partnership between theory and practice underpinning the work of the Centre as a whole. Theory, the Board explained, was vitally important if values-based practice was to avoid the fate of so many other initially promising initiatives, in becoming 'dumbed down' under the bureaucratic and other inevitable pressures of day-to-day clinical and managerial concerns. Remember, they said, the American humourist, J.L. Mencken's aphorism, variously cited along the lines of, 'For every complex problem, there is always at least one solution that is clear, plausible – and wrong!' (Mencken, 1920).

This made sense in our circumstances. Through an exchange in the early days of the Centre with (the now late) David Sackett, we were aware of his disappointment that his originally rich model of evidence-based practice, developed in his role as the Founder Director of Oxford's Centre for Evidence-based Medicine, had been, precisely as our Advisory Board warned, dumbed down. Sackett's original model of Evidence Based Medicine had three elements: it combined evidence of various kinds (appropriate to the question of concern) with clinical experience, and, yes, patients' individual values (Sackett *et al.*, 2000, p. 1) – a far cry then from much of today's evidence-based medicine in which evidence, and indeed evidence of only one kind (prototypically from randomised controlled trials), is considered relevant.[7]

[6] Its full title is The Collaborating Centre for Values-based Practice in Health and Social Care, St Catherine's College, Oxford, see https://valuesbasedpractice.org.

[7] The relevance hierarchy is upended for values-based practice in which lived experience comes out at the apex (see Fulford, 2020).

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Thus forewarned, the work of the Centre for Values-based Practice has been pursued explicitly within an ongoing dynamic between theory (primarily but not only philosophical theory) and practice. The dynamic, we should add, is indeed 'ongoing': there is much of theory that remains untouched let alone explored. But by way of illustration, we will outline two areas showing the power of the theory-practice dynamic to which our Advisory Board pointed us – first, the origins of values-based practice in ordinary language philosophy; second, its ongoing development by way of a now growing range of other philosophies, both European and non-European in inspiration.

Origins in Ordinary Language Philosophy

The poster child of mid-century ordinary language philosophy of the 'Oxford school' was J.L. (John Langshaw) Austin, at the time White's Professor of Moral Philosophy and a Fellow of Corpus Christi College. In developing his philosophy, Austin built on the observation that we are in general better at using everyday concepts (including many of the concepts with which philosophers struggle) than we are at defining them. Something similar had been pointed out several centuries previously by the early Neo-Platonist philosopher and Bishop of Hippo, St Augustine, in his *Confessions* (Book 11, Chapter 14, No. 17): 'What then is time?', Augustine wrote, 'Provided that no one asks me, I know. If I want to explain it to an enquirer, I do not know' (Chadwick, 1992). Why not, therefore, Austin and others argued, explore the way concepts are actually used in ordinary (i.e. non-reflective) contexts rather than (as philosophers have traditionally done) getting out of our depth with trying to define them.

Ordinary language philosophy, so defined, has been subject to much criticism, some for what it is, some for what it is not (see for example various essays in the collection by K.T. Fann, 1969). Rather than exploring its pros and cons in general we will focus here on four aspects of the resources it brings to the development of values-based practice.

1) Focusing where practice 'is at'

As a method, ordinary language philosophy is highly compatible with the challenges of practice in that it focuses on where the conceptual problems of practice are 'at', i.e., in ordinary everyday usage. Much of clinical care (at least in acute hospital medicine) can

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proceed up to a point effectively with little regard to conceptual problems; there are after all in such contexts sufficient empirical problems with which to engage. But where conceptual issues arise in health care (notably, as we describe further below, in mental health care), they arise as problems in everyday practice and are framed in the language of practice.

The language of practice, moreover, as Austin himself pointed out, is particularly well displayed, again consistently with clinical experience, through case studies. Towards the end of one of Austin's most explicitly methodological papers, *A Plea for Excuses*, having worked from legal case reports, he directs philosophers to the (as he believes) richer resources of case material in (what he calls) 'abnormal psychology': 'There is', he says, anticipating by some forty years the development of values-based practice in mental health (described below), 'gold in them thar hills' (Austin, 1956/7, p. 24).

2a) A more complete view: the three words training exercise

Austin had a very modest view of his proposals for ordinary language philosophy. Indeed, he repeatedly caveated its potential. One such caveat was the extent of its outputs: it gave us, at most, and only with concepts of the kind for which it was suited, a 'more complete view' of their meanings. When we try to define a complex concept, so Austin argued, we tend to focus on one or other aspect of its meaning; exploring ordinary usage, on the other hand, expands our view to encompass a more complete view of its meaning. Exploring ordinary usage thus gives us what another philosopher working in this tradition, Gilbert Ryle, called the 'logical geography' (Ryle, 1949, 1963 edition, p. 10).

The Austin/Ryle 'more complete view' is directly reflected in the three words training exercise for values-based practice described above. Merely asking participants to 'define' what they mean by 'values' would leave them at best bemused. As a word association exercise, by contrast, participants see for themselves the diverse aspects of the meaning of this complex concept: that it is broader than ethics, highly individual, and so on (though not inchoate); and through guided discussion they come to embrace a shared summary of these meanings for practical use as 'anything that matters or is important to the individual concerned'.

2b) A more complete view: the fact/value distinction in health care

The Austin/Ryle 'more complete view' also has substantive implications for our understanding of the concepts (disease, illness, *etc*.)

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defining health care. Indeed, the guiding model of values-based practice – as a partner to evidence-based practice supporting clinical decision-making in all areas of healthcare – is itself an aspect of this more complete view.

Again, we will not have space to develop this aspect of the theory underpinning values-based practice in detail (but see the More about Values-based Practice at: values-basedpractice.org). The model starts from an observation of another of Austin's pupils, and a successor as White's Professor, R.M. Hare, that we can sum up as 'diverse values become visible values' (Hare, 1952, p. 123 *et seq.*; Hare, 1963; this idea is incorporated in the process elements of values-based practice as the Squeaky Wheel Principle, see Figure 4). Combining this with the work of the American philosopher Hilary Putnam on facts and values being distinct but not dichotomous (Putnam, 2002)[8] suggests that health concepts are always hybrid, i.e. part-fact/part-value (Fulford, 1989). We see this, notably, in the overtly value-laden concepts of mental disorder (discussed further below); but health concepts may appear to be value free where (as in the context of life-threatening acute hospital care) the operative values (such as, in this case, relief of pain and saving life) are widely shared.

It is this hybrid model, in essence, by which values-based practice has been guided throughout: from its original theoretical formulation and development in mental health, through its wider partnership with evidence-based medicine, to contemporary applications such as the shared decision-making based on evidence and values that (as described above) is at the heart of today's person-centred clinical care.

3) A collaborative approach

Integral to Austin's modest conception of ordinary language philosophy is his idea that philosophers should model themselves on empirical scientists by collaborating in teams rather than (as they have traditionally done) working alone as 'sole traders'. Austin's inspiration for this idea was his experience as an intelligence officer in the Second World War: he had been impressed by the way teams could solve complex problems by tackling them piecemeal.

[8] Read as arguing that the distinction between fact and value (or description and evaluation) is necessary to ordinary usage even though it cannot be traced all the way back to individual examples of pure forms of either.

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In the development of values-based practice we combined Austin's ideas on team work with the quasi-empirical nature of ordinary language philosophy (he calls it at one point, philosophical 'fieldwork', Austin, 1979, p. 25), to employ a hybrid philosophical/social science methodology to explore differences of implicit values within multidisciplinary teams (Colombo *et al.*, 2003; and Fulford and Colombo, 2004). The key result from this work – that the range of implicit values exhibited by team members matched the range of implicit values exhibited by patients – became the basis for the 'extended' multidisciplinary team of values-based Practice (see Figure 4).

4) A starting point – sometimes the first word, never the last

Ordinary language philosophy comes with a further important caveat, again, repeatedly emphasised by Austin, namely that he was not proposing anything in the way of a philosophical sinecure. One of Austin's pupils, and later biographical editor, Sir Geoffrey Warnock, reports Austin as opening a seminar on ordinary language philosophy with 'I want to say something today about one way of possibly getting started with some kinds of philosophical problem' (Warnock, 1989, p. 6). Elsewhere Austin himself writes in similar vein to the effect that ordinary language philosophy may sometimes be 'the first word (but) never the last' (cited by Warnock, 1989, p. xx).

This caveat, so often ignored by the critics of ordinary language philosophy, has many important consequences for values-based practice, not the least of which is its recent flowering into other areas of philosophy. Ordinary language philosophy has proven highly effective in getting values-based practice started. In Austin's terms it has been a fruitful 'first word'; but as Austin himself anticipated, and as we illustrate in the next section, it is far from being the 'last word'.

Ongoing Development and Other Philosophies

As several times noted, values-based practice was developed first in mental health. This might seem surprising given the widely perceived 'second-class' status of mental health among health disciplines. It reflects, however, another of Austin's insights, namely that the most productive areas for ordinary language philosophy are often just those areas where the concepts of interest appear to break down or in other ways cause difficulties. This is not unlike the medical example of diabetes (where the pancreas stops working properly) leading to the eventual discovery of insulin. Austin used the

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metaphor of a 'blinding veil of ease and obviousness' to capture the idea that the full meanings of complex concepts may be hidden from us by the facility with which we use them in unproblematic contexts (Austin, 1956/57, p. 23).

Following Austin's lead, the conceptual challenges presented by mental health are thus opportunities for breaking through the 'blinding veil' to a more complete view of the meanings of the health concepts as a whole. This is indeed what we find. If the conceptual insights summarised above are correct, the overtly value-laden concepts of mental disorder are not an indication, somehow, of deficiencies in the mental health disciplines, but a sign rather that the health concepts as a whole are (in part and albeit often covertly) evaluative in nature.

This is of course an arguable claim (though the argument, as recent commentators have pointed out, has moved on from *whether* the health concepts are in part evaluative in nature to *where* the line between fact and value should be drawn, see Stein *et al.*, forthcoming, 2023). But even if it is correct, we should anticipate (again, following Austin, point 4 above) that this will not be the last word on the subject. This indeed has been our experience in developing values-based practice. We noted above the results of combining ordinary language philosophy with methods derived from the social sciences. We will focus in the rest of this section on the results of extending the theoretical base of values-based practice to other areas of philosophy in the context, first of mental health, then of health care as a whole.

Philosophy, Values-Based Practice and Mental Health

As noted above, values-based practice, reflecting the overtly value-laden nature of concepts of mental health, was developed first for use in this area of health care. And it is the challenges presented by the values operative in mental health that continue to drive the development of values-based practice in mental health.

To be clear, there is much in mental health (as of course there is in bodily health) that is susceptible to values-based interventions based only on its original formulation in ordinary language philosophy. The outcome of Natalie's story at the start of this chapter, of 'Dancing with Angels', was a tragedy precisely because it could have been avoided if her self-evident values had been listened to. Indeed, the very concept of 'recovery' in mental health is values-driven in that, as noted above, recovery means recovering a good quality of life as defined by the values of (by what is important to)

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the person concerned. Which makes it all the more important to recognise that the operative values may be considerably more obscure than in Natalie's story. How, for example, should we understand people with anorexia who make clear, just as explicitly as Natalie made her values clear, that they value fasting and weight loss even more than their own death? Or how should we understand people with addictive disorders who both wish and do not wish to continue their addictive behaviour?

Developments in phenomenologically-enriched values-based practice are proving effective in areas such as these, where the operative values are obscure to ordinary empathic understanding. Thus, the Italian philosopher and psychiatrist, Giovanni Stanghellini, has developed a range of insights based on Jean Paul Sartre's three-way phenomenology of the body, into the pre-conscious (or pre-reflective) life world of people with anorexia (Stanghellini, 2017). Combining this with empirical methods he has developed both therapeutic (Stanghellini, 2019) and research interventions (Stanghellini *et al*., 2012). Similar phenomenologically-inspired work on addictive disorders, drawing in this instance on dialectical methods and extending to policy-level interventions, has been developed by the Brazilian phenomenologist and psychiatrist, Guilherme Messas (Messas, 2021; Messas and Fulford, 2021a and 2021b).

In this and other areas, then, we have seen a coming together in values-based practice of two traditionally separate strands of European philosophy, respectively analytic philosophy and phenomenology. Analytic philosophy has much to offer still, it should be said. Take, for example, Anna Bergqvist's work on the relationality of values in psychiatric ethics and shared decision-making (described below). And in a contrasting area, the mathematician and philosopher, Philipp Koralus, has developed a computable model of rationality based on semiotic logic (his 'erotetic theory' of rationality, see Koralus and Mascarenhas, 2013) with potentially important implications for understanding and intervening in severe mental disorders such as schizophrenia (Parrott and Koralus, 2015).

A further and quite different area of development has drawn on philosophies that are non-European in origin. Such philosophies have found important applications for example in relation to the much-contested area of race relations in mental health. Leading the field in this has been the activist and expert-by-experience, Colin King, drawing notably on the work of the French Caribbean philosopher and psychiatrist, Franz Fanon (King *et al*., 2021; Fulford, King, and Bergqvist, 2023). King's work identifies the origins of racial bias in psychiatry in unacknowledged values of whiteness operating

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through judgements of rationality implicit in psychiatric diagnostic categories. This has implications for a remedial approach based on values-based principles of co-production across lines of colour.[9] This work is important in its own right and in addition has wider implications for reducing the notorious vulnerability of psychiatry to abusive uses for political (rather than legitimately medical) ends.

Philosophy, Values-Based Practice, and Health Care

Given Austin's mental health first message, we should not be surprised to find theoretical developments in the rest of healthcare following the lead set by mental health, drawing that is to say on both European and non-European philosophical sources. The driver though in the context of bodily health is not (in general) empathically obscure values but the need to expand the horizons of values-based practice from individual to social values.

The need for such an expansion was pointed out originally by the Indian analytic moral philosopher Shridhar Venkatapuram (2014). Pointing to the findings of the epidemiologist Sir Michael Marmot, with whom he had been working, Venkatapuram argued that in focussing on individual values, values-based practice was misaligned with current evidence suggesting that the main drivers of pathology in most areas of bodily health were not individual and biological but social and political.

Our response to this has been, in part, an open access collection of case studies in social values and health care edited by the Bulgarian psychiatrist and philosopher Drozdstoj Stojanov (Stojanov *et al.*, 2021). This includes case studies from the South African philosopher and psychiatrist Werdie van Staden on what he has called Batho Pele, a distinct form of values-based practice based on African philosophical concepts that, uniquely, transcend the individual/social divide: van Staden's contributions to Stoyanov's volume illustrate the impact of Batho Pele in both clinical (Van Staden, 2021) and policy (Ujewe and Van Staden, 2021) contexts.

A second philosophical response to Venkatapuram's challenge has been work by the the analytic philosopher Anna Bergqvist (who is Theory Lead for the Collaborating Centre), based on Iris Murdoch's work on the relationality of values in psychiatric ethics (Bergqvist, 2022), moral philosophy (Bergqvist, 2018a, 2018b), and

[9] See https://valuesbasedpractice.org/co-production-in-mental-health-as-a-path-to-race-equality/.

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shared decision-making (Bergqvist, 2020). According to this work, we should understand values in general, whether expressed individually or socially, as arising not as it were 'within one's head', but discursively in the interactions between people. The analytic philosophy driving this conclusion has wide-ranging implications for all areas of health care. In Bergqvist's own work, it has been guiding her development of closer collaboration between experts-by-experience and experts-by-training in multiple areas ranging from the shared clinical decision-making, outlined above, through to policy based on new models of public mental health.[10]

Conclusions

In this chapter we have introduced by way of two interactive exercises the key features of values-based practice and then outlined the importance of philosophy both in its origins and its ongoing development.

A couple of caveats – one practical, the other philosophical – are necessary. The practical caveat is that values-based practice is only one tool in an increasingly rich toolbox of resources available to health and social care for working with values. Besides ethics and medical law, other tools in the values toolbox include decision analysis (the basis of online and other clinical decision aids) and health economics. Values-based practice as we have described adds to the toolbox a resource for working particularly with individual values (whether or not relationally derived) in the context of shared clinical decision-making. Values-based practice, so understood, is in this respect, again as we have indicated, a partner to evidence-based practice in supporting shared clinical decision-making. In its partnership with evidence-based practice, however, values-based practice is most effectively deployed alongside other tools in the values toolbox.

Our philosophical caveat is that the theory-practice dynamic described in the second half of the chapter should be understood as a two-way dynamic, with philosophy benefitting as much from its exposure to practice, as practice benefits from its exposure to philosophy. Both sides of the dynamic are important. So important has been the contribution of philosophy to practice that there is a sense in which values-based practice could be regarded as a philosophy-into-practice offshoot of the wider resurgence of interdisciplinary

[10] See https://valuesbasedpractice.org/what-do-we-do/networks/values-based-practice-in-public-mental-health-network/.

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work between philosophy and psychiatry that emerged in the 1990s (Fulford *et al*., 2003). There are of course many relevant areas of philosophy that have still to pick up the opportunities offered by values-based practice (the philosophy of science, for example, and political philosophy). But from the start there have been clear examples of the benefits the other way, of interdisciplinary work in philosophy and psychiatry being of as much benefit to philosophy as to practice.[11]

The opening story in this chapter, of the tragic outcome of Natalie being denied her dancing with angels, was intended to root the chapter in the realities of day-to-day clinical care. As a story from mental health, the 'mental health second' stereotype still so widely prevalent in health care, may make the story appear less relevant to other 'more scientific' areas. This is perhaps why, it may be thought, so much of the recent practical development of values-based practice noted in the first half of the chapter has been in areas of bodily medicine such as surgery. But Austin's observation guiding the philosophical development of values-based practice shows the opposite to be the case. Recall that in ordinary language philosophy, Austin argued, we have most to learn from where things go wrong. This then suggests a quite different – a 'mental health *first*' – bottom line from Natalie's story: that mental health in leading the development of philosophically-informed values-based practice, far from being in second place, is showing the way forward for person-centred health care as a whole.

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