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VALUES, HEALTH AND HEALTH CARE

Learning Outcomes

By the end of this chapter, you should be able to:

- Identify, describe and discuss what is meant in talking about 'values';
- Discuss, especially as health care professionals (or professionals-in-training) how values are acquired;
- Describe and discuss different ways in which it is possible to understand, and talk about, the value of health;
- Understand the nature of the connection between values, on the one hand, and ethics, on the other, with particular reference to the health care context.

Introduction

I argued in Chapter 1 that questions of values and ethics were central to each of the three case studies I spent time thinking about. These case studies, I also argued, were only representative of much more extensive values-related debates that are taking place all the time in relation to almost every health care situation we might encounter or be involved with. So values are fundamental to, and embedded in, the whole practice of health care.

But if we are serious about any exploration of values in health care, we need first of all to understand what values actually *are*. Where do they come from? Why do we hold the values that we do? Why do others possess values that are different from our own? These are some of the questions that I will spend part of this chapter trying to address. In the light of these discussions about the nature of values, I want to think about how we might understand **the value of health itself**. Can we expect unified understanding? If not, what different perceptions might exist and why exactly is the value disputed and contested? Thinking about these questions leads us back into the territory of health care, with all its ambiguities and difficulties. Finally, I want to think a little about

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the relationship between **values**, on the one hand, and **ethics**, on the other. Are they connected and, if so, how? Is the link uncomplicated or does it create problems for further understanding and exploration? I want to argue that questions related to the connection between values and ethics pose major difficulties for understanding the nature and purpose of ethics itself. The debates in this chapter provide a springboard for future arguments through the book about values and ethics in the context of health care.

What are Values?

The simple and obvious answer to this question is that they are those things we value, or are able to find value in. The *Oxford Dictionary* talks about values as:

The amount of money or other commodity or service etc. considered to be equivalent to something else for which a thing can be exchanged ... Desirability, usefulness, importance ... The ability of a thing to serve a purpose or cause an effect. (Oxford University Press, 1983: 748).

Like many apparently straightforward definitions, though, these ones prompt us to more questions than they provide answers. If something is desirable, is that the same as it being useful or important? Is it possible for something to be one of these things, but not the others? This seems highly likely. The train that I catch home from work in the evening is useful and important to me as it gets me back to my house (and so for myself it has value), but I'd be reluctant to say that, in itself, it was *desirable*. (Perhaps I might if I was a train enthusiast. But if there is any desirability for me in this example, it lies in what the train *does* – it gets me back home, where I want or desire to be – rather than what it *is* – a particular locomotive class, or a particular configuration of coaches, say.)

This rather simplistic example points up some important things. First, it seems to suggest that there may be **different kinds of values**. We may value something because of its desirability or its importance or its usefulness, but if something is valuable to me, say, it certainly doesn't have to be all of those things (although I would argue that it has to be at least one of them to possess value). Second, it points to the idea that different people are likely to value different things, and even if they hold the same thing as valuable, they may value that thing in different ways. To emphasise this idea further, take the final component of the definition above – something possessing value because it serves a purpose or causes an effect. To me, the ability to read is a value. It is a value because it gives me great pleasure, allows me to escape into alternative worlds, and so on. These are the effects that reading has on me, and this is more often than not my purpose in sitting down to read. For somebody else, the value of the ability to read lies solely in its allowing them to make sense of the world, to follow instructions, to navigate their way through public transport systems, and so on. For this other person, that value can be described (in terms of purpose and effect) simply in those ways. It can be described like that for me as well. (After all, where would I be if I couldn't read the instruction manual for my washing machine or work out where I was going on the Tube?) But I would

need to ‘add in’ the extra bits of description, such as pleasure and so on, in forming my own account of the value of the ability to read.

Much philosophical work has gone into trying to understand the nature of values. The moral and legal philosopher Ronald Dworkin has developed a useful account of values and their nature. He argues (Dworkin, 1995) that there are three kinds of values:

- Subjective values;
- Instrumental values;
- Intrinsic values.

Subjective values are those that relate to preference or ‘liking’ (Downie et al., 1996). A value is **instrumental** if the thing that I value has usefulness for me. Something holds **intrinsic value** if we cannot reduce that value to considerations of preference or of utility. We might regard this kind of value as applying to things that are so essential to being human that talk of liking or usefulness of the value seems absurd; we just know this thing, whatever it might be, has fundamental (intrinsic) value. Something might have *only* subjective or instrumental or intrinsic value, or it might possess a combination of these.

Perhaps examples might help to develop our understanding of Dworkin’s classification. I have deliberately chosen ‘non-health’ examples for the time being in order to allow us to focus on the nature of valuing itself before I move on to consider the shape of values that might be related to health and health care. Let’s go back to the train I catch to and from work – my daily commute. Imagine I’m returning home quite late one evening after spending the day meeting and teaching students. I’m tired but in good spirits. As I cross the station concourse, I catch sight of a stall that sells sweets and drinks. Suddenly I think that I fancy a chocolate bar. I don’t need one – I’m not at all hungry – it would just be nice to have. That chocolate bar would have **subjective value** for me. I just happen, at that moment, to have a liking for the taste of chocolate and a preference for this kind of snack over, say, a bag of crisps, or something else that would be far, far better for me!

I buy the chocolate bar and head for the train. I want to suggest, as I implied before I introduced Dworkin’s classifications, that the train possesses **instrumental value**. It has usefulness or utility for me in that it takes me (usually with not that much fuss) from home to work and back again. Of course it might also have subjective value; I greatly prefer travelling by this train to driving through congested city streets to reach my workplace, but if I were asked to think about the train’s value to me I would probably do so in instrumental terms.

Imagine now that it is some time later and I finally arrive home. The curtains are drawn at the windows of my house and I can see the dim glow of lamps through them. I open the front door and there is a shout of welcome. It’s warm inside. One of the family makes me a cup of tea and I sit down in a comfortable chair to drink it. All of the things that I’ve mentioned – the warmth, the welcome, the cup of tea, the comfortable chair – have instrumental and subjective value to me. But they also embody the idea of *home*,

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and I want to suggest that the value of home (and the things it represents) extends beyond subjectivity or instrumentality. Its value is arguably **intrinsic**. The nature of humanity and being human is such that ‘home’ possesses fundamental value. It provides warmth, shelter, companionship, love, and so on. Of course the value of home (and associated values) might also be thought of as instrumental. For example, the fact that I possess them helps me to get on with my life and work in ways that I might not be able to do if I was in different circumstances. However, I can’t see them wholly in these terms and others might be shocked if I tried to do so. What if I said that my home and family were valuable to me only in so far as they helped me to get on with my own life? At best, I would be thought cold and calculating. The truth seems to be that the value of ‘home’, and many of the values associated with it, might not be reducible to ideas of preference or utility.

Q: What are the things you value in your own life? Construct a list, trying to classify the things on your list according to whether you think their value is subjective, instrumental or intrinsic (or a combination of more than one of these things). If you have any difficulties in coming up with your classifications, ask yourself why this might be the case.

The problem of intrinsic value

One of the difficulties that might have emerged in the process of thinking about values and what is valuable in your own life may have been that of trying to get to the heart of what might have **intrinsic value**. It’s possible that you were easily able to identify things that have subjective and instrumental value for you, but that it was much harder to alight on things that might be regarded as intrinsically valuable. More particularly, is it right to suggest that there are values whose worth lies mainly or wholly in their intrinsic nature? For example, it’s possible that one of the things you might have come up with in your ‘values list’ is the value of the education that you might be currently acquiring, or have acquired in the past. But is it right to talk about ‘the value of education’ as valuable in itself? Surely, we value education because of what it does for us; it makes us more employable, gives us skills to cope with life, perhaps for some is enjoyable (and so also has a subjective, ‘liking’ or aesthetic value). Going back to the example that I provided earlier of some of my own values, I argued that the idea and reality of ‘home’ had intrinsic value for me. But is this really the case? Can I actually think of ‘home’ in any other way than the subjective and instrumental value that it provides for me (warmth, companionship, shelter, all of which I enjoy and need in order to get on with life)?

Philosophers themselves have had long struggles with the idea of intrinsic value, trying to tease out what it actually means (Audi, 2004; Baird-Callicott, 2005; Williams, 2002). They have tried to suggest that intrinsic values are those which can be recognised as such from an impersonal or general point of view (Williams, 2002). For example, ‘truth’ has value for me because of its

instrumentality. It is important for me that the person waiting at the bus stop is telling the truth about the time of the next bus, otherwise I will miss it. Equally, it is important that I tell the truth to the person who comes up to the stop and asks me about the times. If I have previously lied to her, the next time I'm in a fix about bus schedules, I might ask the very same person and on the basis of her past experience, she may well go ahead and lie back to me. But the value of truth telling lies beyond its personal use to me. I can see the value of telling the truth in a whole range of situations that don't concern me at all. Thus 'truth' assumes a general or impersonal value. We might call this argument for the nature of intrinsic values the **general recognition** argument.

Again, and somewhat in contrast, other philosophers have tried to frame intrinsic values as those things in our lives that make living them worthwhile (Audi, 2004). Continuing with the 'truth' example, if I live a life in which the value of truth plays an essential part (I believe it is fundamental that I do my best to tell the truth in all situations, and so on), this will contribute to the nature of my life as worthwhile. On the other hand, if I imagine living a life in which truth plays no part at all, where my existence is riddled with lies and deceit and the effects of these things, then for me this won't constitute a worthwhile life at all. This is because of the kind of value that 'truth' is. By this account, the worth of intrinsic values lies in our *experience* of them as formulators of 'lives that are worth living' (Audi, 2004: 123). We could call this argument for the nature of intrinsic values the **experience of worthwhile living** argument.

The contrast between the two arguments for the nature of intrinsic values should now be clear. The 'general recognition' argument does not depend on our necessarily having experience in our own lives of the value suggested as intrinsic; we can impersonally recognise its intrinsic worth for the peace and progress of humanity. The 'experience of worthwhile living' argument, on the other hand, obviously does depend on us having (if only by proxy) a sense of the experience of living 'the worthwhile life' through these values (or what it would be like if these values were absent from our lives).

Q: Can you think of any difficulties with these two arguments for the nature of intrinsic values – on the one hand, that they are those which require 'general recognition' and, on the other, that they are those we need to possess in order to lead 'worthwhile lives'?

It seems to me that the problem with both arguments is that neither of them makes it very clear what might actually count as an intrinsic value. Sticking with the 'truth' example, what is it about truth that makes us suggest that it should hold general recognition as an intrinsic value? There are occasions when truth actually doesn't have value. Imagine that I know the person asking me about bus times is a suspect in a crime (I recognise her face from photographs on posters). Surely, rather than helping her to move with ease, I should be offering false information so that I have time to go and call the police and

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she can then be arrested? Equally, it seems difficult to suggest that there is just one set of values connected to the experience of living ‘the worthwhile life’. We would probably more reasonably believe there is a range of values that might or might not contribute to the experience of worthwhile living, depending on the particular context of the life concerned (and thus that might be regarded as intrinsic).

One way out of these problems might be to argue that something has intrinsic value when all other kinds of value (for example, instrumental) have been stripped away from it (Baird-Callicott, 2005). If we agree with this, then both the ‘general recognition’ and ‘the experience of worthwhile living’ arguments for the nature of intrinsic values become less difficult. What matters is not so much whether we are able to generally recognise a value as intrinsic; or have direct experience of the nature of the value that suggests to us it is intrinsic. Rather, what counts is whether our analysis of any value we choose to examine will result in us being able to see it as disconnected from any consideration of usefulness, preference, and so on.

Thinking About...

Take one of the things from the list you constructed earlier of what is of value in your own life. Thinking as carefully as possible, try to disentangle usefulness, preference, liking, and so on from this value so that it stands independently of these things and therefore might possess *intrinsic* value.

The Acquisition of Values

It is possible, though, that even applying this level of close thought to a value or values will not yield the conclusion that the value concerned is intrinsic. Or at least, we can’t deny that such a conclusion might be disputed. I might have satisfied myself that ‘family’, say, has intrinsic value. However, somebody could come along and assert that if I *really* thought about it, I would recognise that I always have to connect the value of ‘family’ back to thoughts of its use to me or to wider society, my enjoyment of the comfort it brings, and so on. The point is that I could pare down something to what I believe is its ultimate intrinsic value, but the result of my exercise might well be challenged.

Reaching the position that it is hard (if not impossible) to identify a definitive set of intrinsic values – values that are so important we cannot reduce them to questions of preference or usefulness – is by no means a dispiriting one. What it serves to emphasise is that the form and nature of values can always be disputed. This is especially important in relation to health and health care, where experience tells us that there is much disagreement about what is important, and about what should be done and how we should do it. If we recognise such disagreement as emerging from differences in values, then its strength and its long-lasting nature will become much more explicable

because we have seen how slippery and difficult values and their analysis can be. In order to begin to understand and untangle the nature of such disagreement (although not necessarily to resolve the disagreement itself) an important thing to do now is to try to work out **how and why values are acquired**.

Q: What do you think are the sources of the values that you hold?

Your answers here are likely to have produced a *range* of possible sources of your values. These might have included places of education (school, college, university) or places of informal education, family and friends, local community, media, religious groups, political parties, professional mentors or peers, and so on. Each of these (and other sources that you might have thought about) is likely to be powerful in shaping what we actually value (Halstead and Reiss, 2003).

Generally speaking, Western societies are founded and work on a framework of what we might call **liberal values**. While liberalism itself is hard to define, it is widely accepted as involving a set of values that place individuals and their freedom at the centre of debate and decision-making about what is important and what should be done. So a 'list' of liberal values would probably include things like personal autonomy, openness, equality of opportunity, democracy, and so on (Halstead and Reiss, 2003). However, there is a need to recognise that while these kinds of values are widely accepted and viewed as crucial for the proper functioning of our society, they are not *universally* agreed upon. Even if we agree that the kinds of values I've just listed are important, we might well dispute the exact nature of that value. For example, I might agree with the value of democracy, but would I be happy about a political party with very extreme views (to do with 'race', say) being allowed to participate, at least without some constraint, in the democratic process? Even within our liberal society, values associated with liberalism might be widely accepted, but not necessarily by everybody. Nor is there likely to be uniform agreement on their exact nature.

At least part of the reason for this lies in the fact that while we might all be members of a liberal society, precisely how we acquire particular values – who or what mediates or transmits them to us – will vary from person to person. Two strong sources of values identified by Halstead and Reiss (2003) are religion (of whatever particular kind) and the family. To demonstrate the significance of these sources and how they can profoundly shape the values of those influenced by them, consider this example. Suppose that Bert has been brought up within a strongly evangelical Christian family. His father had very definitely been the head of the family. His mother had never gone out to work and had always deferred in any matter to her husband. The whole family had gone to church every Sunday, and Bert had attended Bible classes and youth groups regularly during the week. The biblical message and biblical values

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were conveyed strongly at each of these occasions, and enacted at home. Now think about Diane, brought up in a family where religion has no significance at all, and where both her mother and father went out to work, brought home equal amounts of money and took equal part in all family-related decisions.

It is easy to imagine Bert and Diane emerging from their separate experiences of childhood and youth with quite different views about the nature and limits of so-called liberal values, as well as particular values inspired by their own family and religious histories. For example, Bert might believe that there are strict limits to the value of autonomy, so that complete personal licence and freedom can't be allowed in, say, sexual relationships. Sex is only permissible after you have married someone. Diane, on the other hand, might believe that freedom extends to all areas of life, including choices and decisions about when she has sex, and with whom she has it.

Of course, somebody could argue that this is a rather simplistic view of the outcome of childhood experiences of religious and family values. We could imagine that either Bert or Diane (or both), as adults with the capacity to value as they wish and enact their own lives, might adopt contrary values to the ones anticipated by their development. At the very least, they might pursue and agree with a set of 'middle of the road' values that could turn out to have much in common with liberalism in the general sense I described before.

I certainly don't want to deny the possibility (very often a reality) of people shaping and deciding their values for themselves. On the other hand, there is a need to recognise the complex interplay between what we might call individual personality and the culture, institutions and society in which that personality dwells (Tones and Green, 2004). If this is recognised and accepted, then what matters about the Bert and Diane example is not so much what particular values they hold at the moment. What is important is our belief that these have emerged, and have the particular nature that they do, precisely because of the entwining of our individual selves with the family, culture and society within which we have grown up and live.

Values and Health Care Professionals

But there is another dimension to the acquisition of values in the case of those professionally involved in health care, or training for such involvement. It is that the process of professional training *in itself* inculcates, or further strengthens, particular values, or ways in which values are regarded (Duncan, 2007).

One of the things any health care professional has in common with another is that they will both have undergone a lengthy period of training and education before being accredited and allowed to practise independently. This applies to doctors, nurses, pharmacists, physiotherapists, occupational therapists and the whole range of professionals working in health care. Indeed, we can regard this lengthy training as one of the 'traits' of being a professional, along with others such as specialised skills, and a body of specialist knowledge to which the professionals concerned alone have proper access (Hoyle, 1980). This education and training (often undertaken in arduous conditions and at highly formative points of peoples' lives) has broadly two outcomes:

- Professionals learn what to do and how to do it;
- They learn what to **believe** and what to **value** (Duncan, 2007: 25–26).

This second outcome of professional education and training is especially important for our discussion about the nature and acquisition of values, so it requires a little more discussion. When somebody begins a course of professional training and education, to qualify as a nurse, say, they obviously start to study explicit bodies of knowledge – what we might call ‘nursing or nursing-related knowledge’. Leaving aside debates about the exact nature of nursing knowledge (and even whether specific nursing knowledge is possible) (Edwards, 2001), we can suggest that nurses need to have the kind of knowledge that will enable them to do their job. Once again, there might be debates about what the job – the purpose or ‘ends’ of nursing – actually is. But let’s assume, from Steven Edwards, that ‘plausible candidates’ for the ends of nursing include: ‘The relief of suffering, promotion of well-being, fostering autonomy’ (Edwards, 2001: 9).

To do this job, to achieve these ends, we need certain kinds of knowledge. We need to know how the body works, and how and why it sometimes fails to work (anatomy and physiology). We need to know how and why people function, or find difficulty in functioning, as well as having a clear view of what ‘human functioning’ is itself (psychology, sociology and philosophy). We also need practical knowledge, that is to say, knowledge enabling us to perform professional actions that help relieve suffering, promote well-being and foster autonomy.

Thinking About....

Consider what are, or might be, the ends of your own profession and the kind of knowledge required to achieve these. (If your profession happens to be nursing, consider your reactions to the account above of possible nursing ends and knowledge.)

In responding carefully to this exercise, you will have started to examine and reflect on the purpose of what you do, and as part of this you will have begun to encounter the beliefs you have as a professional, and the values that you hold. For example, imagine that you regard the end (the purpose) of nursing as the relief of suffering. It will be easy to believe, then, in the importance to nursing of knowledge of morbid anatomy and how to deal with people in morbid states (say, somebody who has difficulty in breathing). Such knowledge will thus also assume a value. So the connection between the two outcomes of professional training and education that I described above becomes clear.

The story, however, does not end there. It is relatively easy to imagine health care professionals (or professionals in training) valuing the knowledge they

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hold and the skills they practise. If they didn't, it would be quite reasonable to ask why they were actually doing the job (or training to do it) in the first place. But the type and nature of values held by health care professionals extend well beyond the relatively narrow valuing of particular kinds of knowledge and skill. They extend into what might be called the values of the profession itself.

Let's continue with the nursing example. If I am a nurse, it would be hard for me to accept the value of knowledge and skill related to the relief of suffering if I didn't believe that such relief (one of the potential ends of the profession) was a value itself. We could add to this list of the potential values of nursing by thinking about some of the other things on Edwards' list of nursing ends, or purposes. If nursing is about promoting well-being, then surely well-being itself must be a value. If it's about fostering autonomy, then autonomy has to be a value. We could add to this list further values such as caring, individual welfare, and so on (Duncan, 2007).

My argument now is that the values on this kind of list are not only central to the profession of nursing, but also key to each member of that profession. The same applies across the range of health care professions. If your profession has well-being as one of its central values, then you are likely to share this value (leaving aside for the moment the very thorny question of what 'well-being' actually *is*). To accept this is partly common sense. (Again, how could it be possible to live the life of a professional and be in constant dispute and disagreement with your profession's values?). But my argument is also rooted in a view of how professional values are actually *acquired*.

Health care professionals learn what to value (as well as how to value it) in two different ways: through what might be called the '**explicit**' curriculum; and through what we might regard as the '**hidden**' curriculum (Cribb and Bignold, 1999). The 'explicit' curriculum, as the term implies, is constituted by what is formally taught in both the academic and the professional components of any period of professional training. The 'hidden' curriculum is what is being conveyed about the profession, what it does, why it exists and individuals' places within it in non-formal or informal ways. The 'hidden' curriculum is conveyed and enacted in conversations about patients and other staff during coffee breaks, or in comments about standards of dress by a ward sister to students working on her ward. It is delivered when an occupational therapist is encouraged to write up her patient notes in a certain way, or when a medical social worker's colleagues eye him a little suspiciously as he leaves the office slightly earlier than he should. It is, in other words, a set of unwritten rules that govern development and behaviour in a profession (Duncan, 2007) and to which the professional or professional-in-training has to conform (at least to some extent) if they want to survive and thrive.

If you were to be asked to about your experience of the 'explicit' and the 'hidden' curricula in your own professional training and development, it is highly possible that you will be able to identify and recall the 'hidden' experience much better than the 'explicit' one. I want to suggest that, in general, our 'socialisation into professional values' (Hoyle, 1980) is much more effectively and powerfully done through the 'hidden' curriculum than through our explicit

training and educational experiences. For myself, training as a nurse a number of years ago now, I remember the long night duties sharing the care of a terminally ill patient, say, or the lecture you got from the ward sister for arriving late on a shift, much better than many of the hours of lectures and teaching sessions that we passed through. It was the powerful informal socialisation, the ‘hidden’ curriculum, that very largely shaped my views on the nature of nursing and the values of the profession.

Of course I do not mean to imply that the formal or ‘explicit’ curriculum is unimportant. Quite the opposite, in fact, for the thoroughgoing socialisation into a profession and its values that happens to professionals-in-training is actually a result of a powerful interplay between explicit and ‘hidden’ curricula. We learn what to know and do largely through explicit teaching; and we learn what to believe and how to value what we know and do through the ‘hidden’ curriculum (Duncan, 2007).

The Values of Health Care

The argument I have constructed for the acquisition of values by health care professionals begins to suggest that these values are powerfully transmitted and become deeply embedded in our lives and work. A number of studies have explored and confirmed this idea (see, for example, Becker et al. (1977) writing about medical students undergoing this process, or Clouder (2003) discussing the development of occupational therapy students).

Q: What values do you think are important in health care, and for those working in the field? Take one of the values that you have identified and try to consider what might be its *exact* nature.

In responding to this question, it is highly likely that a fundamental point of reference as you tried to develop a clearer conception of the particular value you identified would have been your professional experience. Say, for example, that you chose to try to unpack the value of ‘caring’ (which we might reasonably assume to be an important value within health care). Possibly, at least part of your framing of the value of ‘caring’ would have involved seeing it as the task of looking after people so they benefit from the expertise that you possess as a professional (or a professional-in-training). It is hard to see how this kind of conception could not have been at least partly formed by the powerful experiences inherent in the process of professional training that I have just been discussing. Equally, if you resist this conception, and instead view that version of the value of ‘caring’ as controlling and paternalistic, you will still be making strong reference to the value as it has been played out in your experiences and observations on wards and in clinics. We cannot escape from our profession, whatever it is, and the ways that it has moulded our conceptions of values, as both acceptance and tales of

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resistance show (see, for example, Armstrong (1983) and the story of his challenge as a young doctor to what he characterises as medicine's overarching values of control and surveillance).

All this leads us to a position in which we can see the values of health care as ardently held and also, when disagreement occurs, heavily disputed. Yet despite this, we may well continue to believe (and want to believe) there are some values that are central to the practice of health care, and of core importance, over which genuine dispute would be difficult. What might these be?

Once more, in the same way that we did in thinking about the relationship between purpose, knowledge, beliefs and values in relation to the profession of nursing, we have to return to the **ends of health care** to try to understand what its core values might be. Indeed, Edwards' 'plausible candidates' for the ends of nursing (relieving suffering, promoting well-being and fostering autonomy) (Edwards, 2001: 9) *might be* reasonably put forward as the ends of health care itself. One thing that *can* quite confidently be asserted is that the ends of health care are not health care *itself*. We do not build hospitals, train professionals, develop technology, administer public health systems and so on in order to understand them as ends in themselves. (Given the frequent focus by politicians and policy makers on these instruments of health care, this is not such an obvious point as it might first appear. Governments of all political persuasion are inclined to talk about how many hospitals they have built, say, or about how much they have reduced waiting times, as if these things were in fact the very ends of health care.)

We develop health care, and fund health care systems, broadly so that we can improve health. This very wide conception of the ends of health care leads us back to the kinds of things that Edwards mentions. From these, we can perhaps suggest that the values central to health care include things like autonomy (associated with further values such as free will, respect and consent), caring (also involving compassion and responsibility) and equality (which might also include values of justice and fairness). Certainly, if we accept that the ends of health care are to do with health improvement, then there are some values that we can automatically (or almost automatically) reject. For example, some people would assert that there is value in ethnic identity (which may well be acceptable) and that some such identities have greater value than others (which it is unlikely that we could accept). This latter idea cannot be accepted if we believe that the ends of health care are to do with health improvement, for we know that the discrimination and injustice consequent on the acceptance of such a value will not improve health. (At least, it will not improve health *for all*, which at the moment I am assuming is implicit in our understanding of health improvement as the ends of health care. Any narrowing of this interpretation of health improvement, whatever the reason, is likely to be highly problematic, as I will discuss in Chapter 8.)

So it seems as if there is indeed a set of values that are core to the health care enterprise, accepting that its ends are to do with health improvement. However, this clarity is only fleeting if we move on to the natural next question – what

exactly do we mean when we talk about ‘health improvement’? What is the nature of the value of health, the one value above all others that must surely be central to the health care enterprise?

The literature is rich with philosophical theories of health and its nature as a value (Cribb, 2005; Downie et al., 1996; Nordenfelt, 1993; Scadding, 1988; Seedhouse, 1998, 2001; Wilson, 1975 provide just some examples of this). There is also a very extensive literature that attempts to understand, often through empirical fieldwork, what both professionals and ‘lay’ people understand by the idea of ‘health’ (see, for example, Armstrong, 1993; Cox et al., 1987; Herzlich, 1973; Porter, 1995; Williams, 1983). In some senses, this literature can be seen as raising more questions than it offers answers to the extremely vexed question ‘What is health?’ However, there are some conclusions that can be drawn from these writings, and that can be connected to our own debates about the nature of values, and of values in health care:

- The nature of the value of ‘health’ is as disputed and disagreed upon as any other health care-related value.
- ‘Health’ can be understood as a value according to all of the kinds of classifications described by Dworkin, with which I began this chapter. I can see health as a subjective value because if I am healthy – through going to the gym or doing cross-country running, say – I feel better and I *like* having that feeling. I can see it as instrumental in value because it enables me to get on with my life and my daily functioning. And it might appear to have intrinsic value because being healthy (from its etymological roots, being ‘whole’) seems to tie in with our idea of what it is to be properly human.
- We can understand the nature of ‘health’ as a value in a range of ways, which can be classified broadly into two. On the one hand, ‘health’ can be understood as an **objective** phenomenon (health is, say, ‘the absence of disease’). On the other hand, what we understand health to be is subject to **interpretation**. This interpretation depends, among other things, on who we are, what kind of society we live in, what gender we possess, and so on. Importantly, there are some who would argue fiercely for health as being no more and no less than an **objective state**, and others who would not waver from asserting that it could be nothing other than **subject to interpretation**. Equally, there are many (and this is a particularly strong feature of lots of ‘lay’ accounts of health) who see ‘health’ as a mix of the objective and the interpretative.

As we start on this exploration of the nature of values and ethics in health care, the problem with ‘health’ taking on this complex and contestable nature – the challenge it offers our discussions – is that it makes the whole enterprise of health care subject to dispute. What should we be doing in health care? How should we be going about it? These questions are central to us but because of the nature of the values of health care, including the value of health itself, they are not at all easy ones for us to try to answer. We can certainly put forward and promote a set of values core to health care, as I have just done. There is good reason to try to do so; after all, we need some kind of compass for our

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work. But there is no guarantee at all that they will be accepted by everyone, or will remain immune to different interpretation. This is at least partly because of the disputed character of 'health' itself.

Conclusion: Connecting Values and Ethics in Health Care

I have spent some time exploring the nature of values and valuing, starting off with the simple claim that values are, basically put, those things that we find valuable. However, as we start to think about the nature of things that possess value for us, we begin to realise that others might think differently about that value, or even place no value at all on whatever it is that is being considered. So if we assert that we need to engage in health care because it produces things that are valuable, and especially more of the value of 'health' itself, there is a need to be careful on at least two counts:

- Others could disagree about the value of the things actually produced by health care;
- There might well be disagreement about the nature of the value that many see as central to health care and its purposes, that is, the value of 'health' itself.

These difficulties give rise to a clutch of further problems. How do we know what we should be doing in health care? What activities, treatments and interventions *should* we be undertaking? What should we definitely *not* be doing? Why should we be setting limits on treatments and interventions at certain points and not at others? The waters are muddied still further by the fact (demonstrated through empirical evidence) that different kinds of people think in different ways about the nature of the central value of 'health'. For example, 'lay' peoples' views seem to differ in at least some respects from those of health care professionals, although we need to take care because this generalisation does not account for the complexities within separate 'lay' accounts. Look back to the three cases that we thought about in Chapter 1 – Dr Irwin and Mrs Murphy, childhood obesity, and Joe, the severely autistic young boy. It is now clearer that how we think about each case (and therefore what we believe ought to be done about it) is related to values that are, or are likely to be, heavily disputed.

This is the point where it is possible to begin connecting our discussion about values together with ethics. A simple view of the nature of ethics is that it is: 'Enquiry into how [we] ought to act in general' (Lacey, 1976: 60). Ethics is also often understood as enquiry attempting to determine what is valuable, and why it should be regarded as such. This latter purpose of ethics has a clear relevance to our discussions about values, and in particular the disputed values of health care. But so does the former, and there is a need to emphasise the connection between the two purposes to help strengthen our understanding of the links between values and ethics in health care.

In my view, the connection between these two separate purposes of ethics lies in the idea that if we have conceptions of what is valuable, we will want to try to produce more of that value and so we need to know how we ought to act in order to ensure that production. Equally, we will want to avoid or limit the possibilities of producing things that will conflict with what we see as valuable. But this enterprise again poses difficulties:

- How do we determine what is valuable?
- What do we do to increase ‘the valuable’ (whatever it is)?

These difficulties are demonstrated by thinking again about just one of the cases in Chapter 1. Somebody might argue that Mrs Murphy was in such pain, in a place so remote from our ordinary understanding of what it is to be human, that she no longer put any value on her own life and its continuation and that we should agree her life had become without value. Thus Dr Irwin was right in helping her to kill herself. However, somebody else could argue that always, in every circumstance, human life has value simply because it is human and therefore the killing was wrong.

This brief reflection on the case starts to emphasise the important connection between the two purposes of ethics: determining what is valuable and working out what to do to create more of the valuable. It also begins to pose another set of questions, this time more especially to do with action. If we want to produce more of ‘the valuable’ (whatever this is), do we pay particular attention to the likely **consequences** of our action? Or does the valuable lie in performing action that we believe to be right **regardless of the consequences**? What kind of action is this likely to be? How will we know when, where and how to perform ‘right action’? These are just some of the questions that have preoccupied ethicists through the ages and into our own time. Discussing them in the context of health care is one of the major themes of much of the rest of this book. But before I embark on that task, it is important to think about how and why ethics became important to health care; and how and why health care became important to ethics. Considering history is one of the ways in which we can try to make the present more understandable.

Chapter Summary

In this chapter, I have:

- Described and discussed different kinds of values;
- Discussed how we might acquire, especially as health care professionals or professionals-in-training, the values that we have;
- Reflected on the nature of ‘health’ as one of the values central to health care;
- Discussed the fundamental connection between values and ethics.

Further Reading

Downie, RS, C Tannahill and A Tannahill (1996). *Health Promotion: Models and Values* (Second Edition). Oxford: Oxford University Press. This is a detailed discussion of the nature of values and how they might impact on public health and health promotion activity in health care.

Halstead, JM and MJ Reiss (2003). *Values in Sex Education: From Principles to Practice*. London: Routledge Falmer. The focus of this book is on the nature of sex education (especially in schools) as a values-laden enterprise. However, it also contains much useful general discussion about the nature of values and how they are acquired.