Moral Discernment, Evidence Based Medicine and Professional Ethics

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Abstract: The history of bioethics and health care research has largely been a history of attempts to identify, articulate and defend principles that explain when and why certain actions, institutions, health care professionals and policy count as right or wrong, just or unjust, virtuous or vicious. After long having been neglected, the so-called particularist challenge to the dominance of principle-based ethics is once again being given serious consideration in medicine and applied philosophy. For instance, there has been a strong emphasis on partiality and the development of personal relationships in the field of professional nursing ethics. Elsewhere in clinical medicine, there has been a renewed interest in the methodology of *narrative medicine*. Nationally in the UK, in view of the Francis Report initial response to the crisis in the Mid-Staffordshire Trust, the language of *discernment, compassion, engagement* and *context* is becoming increasingly important as a focus for debates over the moral and vocational nature of health care and nursing ethics. The paper makes progress with these and related questions by problematizing the use of concepts such as *perspective* and *narrative* in debates concerning evidence-based medicine (EBM) its person-centred rival (PCM) in clinical medicine and medical epistemology.

1. Introduction

My primary aim in this paper is to improve and promote a re-assessment of the role and significance of context in medicine and professional ethics by discussing the methodological implications and presuppositions of moral particularism as applied to medical knowledge and clinical judgement. The history of medical and professional ethics has largely been a history of attempts to identify, articulate and defend principles that explain when and why certain actions, institutions, health care professionals and policy count as right or wrong, just or unjust, virtuous or vicious. Medical ethics has been dominated by principles. However, so-called moral particularists have forcefully attacked the dominance of principle-based normative theories. According to particularists, moral thought and judgement do not depend on (and maybe do not even admit of) the development and application of moral principles but rather require the exercise of practical wisdom and discernment on a case-by-case basis. It is high time to move this theoretical debate into a wider, more practical context.

In recent years, there has been a strong emphasis on partiality and the development of personal relationships in the field of bioethics and professional ethics. Elsewhere in clinical medicine, there has been a renewed interest in the methodology of *narrative medicine* (Charon, 2001). Nationally in the UK, in view of the Francis Report and the Secretary of State for Health's initial response to the crisis in the Mid-Staffordshire Trust, the language of *discernment, compassion, engagement* and *context*, which drives and motivates the distinctive particularist approach, is becoming increasingly important as a focus for debates over the moral and vocational nature of health care and nursing ethics. A confrontation with moral particularism in light of these developments is a good starting point for investigating the question of what an adequate justification of moral and clinical judgements can consist in – after all, particularism rules out some of the most popular answers given by traditional ethical theories and thereby forces to widen the spectrum of possible answers.

We may identify a range of foundational theoretical issues concerning particularity and compassion as applied to the knowledge and ethics of medicine:

(i) Are there good reasons for thinking that applied moral particularism is possible as a bio-ethical theory? Is this limited to any particular methodology in bio-ethical research?

(ii) Is the appeal to particularism a recovery of medical and health care ethics' moral compass, or a symptom of the undermining of the moral foundations of health care provision?

(iii) Can the language of narrative explanation better capture the moral problems confronted by medical professionals, or might it obfuscate and distract us from more subtle and demanding issues in cost-benefit analysis?

(iv) Is there an inevitable tension between particularist approaches and the need for universally applicable standards of efficient and effective care? Should adequate health care policy aim at reconciliation?

Rather than attempting to reach definitive answers to the theoretical status of moral particularism as a normative ethical theory, my primary focus in this paper will be to connect with and problematize the use of concepts such as *perspective* and *narrative* in debates concerning evidence-based medicine (EBM), its person-centred rival

(PCM) in clinical medicine, and medical epistemology. A theme linking my work in these areas is a defence of the centrality of sound moral judgement in potentially unique cases over generalist and impersonal population-based mechanisms for making decisions that typically characterise the evidence-based approach.

2. The Parallel with the EBM/PCB debate: Facts and Value

Academic researchers from disciplines as diverse as epidemiology and bioethics have attempted to devise models of clinical reasoning to assist practitioners in vital decision-making. In particular, the evidence-based medicine (EBM) movement has made huge impact on thinking and policy regarding clinical reasoning, promoting the application of research-evidence from randomised controlled trials to clinical decision-making (Evidence-Based Medicine Working Group, 1992). On a common view (widespread amongst medical students at least), medical diagnosis is a matter of getting the empirical, population-based, facts right, and values come into play in guiding – alongside good evidence-based medicine – treatment and management. Traditional bioethics suggests that values are codified in a set of principles, a proper understanding of which form a kind of moral calculus. So by the application of statistical reasoning to research evidence one learns the facts of the matter, while any remaining evaluative component to decision-making is understood as the application of general ethical principles to the case at hand.

There remains, however, a gap between the aspects of this model (and variants of it) and the reality of decision-making in specific, complex and potentially unique cases. Knowledge derived from empirical, population-based research, while valued for its ability to limit bias, is not directly applicable to the care of individual patients. The gap between clinical research and individual patient care centers on the fact that empirical research is not generally designed to answer questions of direct relevance to individual patients. Clinicians must utilize other forms of medical knowledge, including clinical experience, in order to arrive at the best medical decision for a particular patient. In addition, clinicians must also elucidate and account for the goals and values of individual patients as well as barriers and facilitators of care inherent in the system in which they practice. Evidence-based guidelines and protocols, then, can never be prescriptive. Clinicians must continue to rely on clinical judgment, negotiating potentially conflicting warrants for action, in an

effort to arrive at the best decision for a particular patient.

The implicit dichotomy between facts and values in current debates over EBM described above is at least questionable and arguably diagnosis is itself a process with irreducibly evaluative aspects (see, e.g., Kincaid, H., Dupre, J., & Wylie, A., 2007; Hamilton, 2010; Bergqvist, *forthcoming*). A deductive approach to clinical reasoning is in evidence in early formulations of both components of the model: in EBM the results of clinical research serve as the major premises from which conclusions about particulars are derived, while in dominant impartialist approaches to bioethics, general moral principles form the major premises. Such deductive models do not do justice to the human elements of decision-making, yet many practitioners are reluctant to admit that their resistance to codification makes these elements non-rational. This continuing gap between theory and the practice it aims to inform has led to striking parallel developments in debates about clinical reasoning on the one hand and moral philosophy on the other.[1] We get to what that parallel is by a closer examination of facts and values in a dominant scientistic reductionist conception of medicine and health care.

The scientistic world-view defined what we currently think of as 'biomedical reductionism', the idea that medicine must be 'based on' objective evidence, and the devaluation of the personal and individual experience that is fundamental to medicine is now being challenged by such movements as so-called 'person-centred medicine' and 'value based practice' (see, *e.g.*, Miles, 2009; Miles & Mezzich, 2011)). Recent attention given to personalised and person-centred medicine (PCM) and Value Based Practice (VBP) represents a shift in focus from acquiring statistically reliable knowledge of a general nature to an interest in the complex and potentially unique features of real cases – a direct parallel with the positive particularist claim in moral philosophy that only the exercise of discernment on a case-by-case basis can do justice to the specific, morally relevant features of real cases. These developments are accompanied by a renewed interest in narrative explanation and casuistry, as well as a revival of approaches such as virtue epistemology – an approach to reasoning

[1] As noted by Tonelli (2012), proponents of EBM and traditional bioethics of course recognize the need to 'integrate' specific features of cases into clinical reasoning. However much work remains to be done at the theoretical level on this issue, leaving the problem with practitioners who, despite the wealth of theory in the area, find they must work out for themselves what exactly it means to 'integrate' these features across diverse cases.

grounded in Neo-Aristotelian conceptions of knowledge and practical wisdom, which reject simplistic dichotomies between reason and emotions and focus instead on the attributes of a whole, integrated rational decision-maker.

For many virtue theoretic conceptions of bioethics and methodological particularists like myself, the most intellectually exciting and practically challenging features of VBP are to be found in its denial of two attractive and traditional views of medicine: that, as Tim Thorton (2011) puts it, 'diagnosis is a merely factual matter' and that 'the values that should guide treatment and management can be codified in principles' (p. 988). While I defend these claims of value based practice, in what follows I want to problematize and ultimately reject a third definitive feature of the VBP movement: a radical liberal constructivist view of value whereby the idea of right or good outcome should be replaced by 'right process' – ultimately a form of methodological relativism or subjectivism.

In general terms, while the dichotomy between 'scientific' and 'humanistic' approaches to care is being questioned in the search for a more integrated approach, there are legitimate concerns that the focus on the particular represents a distraction from the need for universally applicable standards of efficient and effective health care, culminating in the reduction of meaning and truth to a perspective. Consider two views about the relationship between rationality, objectivity, judgement and good practice.

3. A false dichotomy

The new person-centred medicine's focus on narrative explanation and evaluative outlooks on behalf of the care takers in the interests of catalyzing awareness of individual patient's *experience* of illness and healing is typically presented as a challenge to the "scientistic" conception of clinical judgement facts as presented in available statistical population based facts. Maybe we can all agree that there has been a shift in focus here in debates of compassion (and, indeed, 'compassion fatigue') view of the crisis in the Mid-Staffordshire Trust, for instance. However, does the relatively uncontroversial observation that new movement of person-centred or value based form of health care aim to connect with patient's personal values and individual histories – individual narratives for short – invite dialogue and spur critical reflection

imply that we need a new model of meaning and objectivity in medical practice? What should such a model be like?

Current thinking with respect to the nature of clinical judgement and diagnosis – especially given focus on individual patients' narratives and external socio-economic environmental factors shaping their personal histories – seems to assume is that the meaning (significance, essence, nature) of some symptom is fixed either the following alternatives:

(1) *Viewer narrative construction*: determined by the individual viewer's narrative (where that might include her own values, memories, socio-political ideals)

OR

(2) *Evidenced based 'health from above' construction*: determined by the "scientistic" conception of the facts as presented in available statistical population based facts.

Much contemporary work on narrative medicine and value/person centred health care urge the conceptual and explanatory priority of the former, patient centred personal narratives, often culminating in the radical individualist contextualist claim that meaning of the symptoms is subjective/personal/perspectival. On this construal then, rather than seeing population based clinical research and its application in the medical profession as authoritative in the determination of the meaning of the observable symptoms, we should instead put the perspective and autobiographical narrative history of the individual patient in the driving seat.

While such radical subjective perspectivalism *could* be read into the PCM and VBP movement it is by no means mandatory and in what follows I will sketch an alternative model.

4. Concept and conceptions: methodological particularism about meaning

It is a mistake to think that radical subjectivity is entailed by the fact of different narratives because these are *conceptions* of the symptoms and situation of diagnosis, not the object of health inquiry and diagnosis itself. There is no implication, or so I

claim, for the meaning or nature of the object of clinical judgement based on the fact of different narratives.

One is easily led to suspicion of narrative explanation as a genuine form of explanation in general by exaggerating the role of interpretation. Taking a leaf from Peter Goldie's (2012) work on historical and autobiographical narratives, part of the problem is that the suspicion that putative supporting documents for any such particular narrative is 'just more text, multiply open to interpretation' motivates the assimilation of narratives and what they are about (p. 153-54). Transposed to the present case, the exaggeration about interpretation and value-sensitivity is the simple point that all these salient features pointed to in making good some particular patient's narrative illness experience are themselves open to radically open-ended interpretation in line with individual viewer's experience and constructive "meaning-making" propensities, to paraphrase a point Michael Baxandall (1991) makes in a different context. I maintain that this way of thinking mis-locates the role of context in clinical judgement and diagnosis. The meaning is not to be found *in* the narrative, whether in terms of some 'authoritative' "health from above" construction or the individual patient perspective. The narrative can reveal (or obfuscate) the object's meaning – but it does not determine the object's meaning. To think otherwise would be a failure of running together what is represented with the representation. So how are we to understand this contrast between the present model of moral discernment in clinical judgement and that of radical constructivist construals of value-based practice?

The emphasis placed on construction and individual patient narrative contexts mentioned above effectively declares that content-involving (and so rationality-involving) phenomena in human life to be inseparable from point or purpose. But nothing in that bare thought precludes an the alternative understanding of perspective and the significance of context of the individual patient, namely that content and human-involving interests and purposes are <u>interdependent</u> such that neither can be understood except in connection with the other. This is a methodological point about knowledge of objects of clinical judgement and diagnosis.

The radical contextualist model of "meaning-making" by contrast, opens the door to something more: to the prospect that we can see content as *determined* by independently specifiable viewer-centred narratives, patterns of attention, or on a larger scale, generic socio-political cultural narratives that are discernible in public

discourse. In so far as the promises of person centred medicine (PCM) and value based practice (VBP) lies in such a reduction of meaning and medical truth to a perspective, it is a new paradigm I think we should resist.

Instead I suggest that we may think of narrative medicine and value based practice (VBP) as a *model of comparison*, deployed in the interests of *uncovering* meaning in a way that is perhaps analogous to the very activity of philosophy itself. Maybe the question of what exactly to be understood in a personalised care is itself an ill posed question. It is this 'dislodging' of ideas that a methodological particularism endeavours to illuminate. If we may think of medicine as taking on this task (as Wittgenstein does with philosophy), we can also preserve a critical perspective in favour of a purely sociological or autobiographical one. Such reorientation of focus makes available a distinctive methodological particularist conception of medical discernment, in which claims to 'objective' meaning *in* patient narratives are criticised not as false *per se*, but as failing to yield the insight about the problem of objective meaning in clinical judgement it was the point of those claims to provide.[2]

Thinking of discernment and professional judgement in personalised care as a model of comparison offers an alternative *conception* of an object of treatment and medical diagnosis. We might think that the object is absolute, and the conceptions of it are perspectival, and stance-dependent. What this means is that the *route* to truth will be stance-dependent, shaped by your conceptions. This is the epistemological/methodological point about knowledge of objects. Nonetheless, locutions such as 'X is objective' are yet legitimate, in as much as there are better or worse ways of conceiving of X. Similarly, in the present context of diagnosis and engagement with patients, we are now in a position to say that the meaning of the object of clinical judgement cannot be accessed except through a perspective, and we can then think of narratives (either personal or, on a larger scale, world-view models of comparison) as providing better or worse conceptions (perspectives) of the object without reducing meaning and medical truth to a perspective.

I end with some concluding remarks about the wider significance of the alternative view in elucidating the use of concepts such as value and perspective in clinical medicine and value theory more generally.

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[2] This paragraph was inspired by recent work on Wittgenstein and contextualism by Jason Bridges.

5. Concluding remarks: the significance of the first person

Once we take seriously the methodological point that the medical facts about the particular patient, the object of clinical judgement and diagnosis, cannot be accessed except through a perspective, an alternative to the conceptual map with which we started emerges. On the new model, 'objectivity' (and, by implication, 'science') is no longer treated as an opposite, mutually exclusive, category to that of the 'subjective' and 'particular' aspect of the patient and the idea of discerning compassionate practitioner. And the reason is that the device of professional medical judgement and discernment is no longer theoretically construed as mere *opinion* in contrast to an "expert" view based on population-based scientific evidence (Miles & Mezzich (2011)). Instead of treating the specific context of the trained practitioner and her practice as itself a type of "evidence" that is to be weighed against independently specifiable statistical medical facts, professional judgement is rather 'the means for adjudicating between alternative sources and weighing their relevance to the individual problem at hand' (Loughlin, *et al* 2013, p. 141).

In the context of moral philosophy, Maximilian De Gaynesford (2010) argues that reference to the first person – first personal thought – in ethical thinking is of greatest importance in understanding the very notions of 'rational agency' (agency that involves responsiveness to reasons) and 'practical reasoning' (reasoning leading to action. Similarly, in the medical context, we may ask what makes it the case that some reason or context of professional judgement is a situation of *mine*? What is the relation of agency that discloses possible medically relevant reason-giving facts as 'open' to someone for whom one can have first personal concern as a responsible practitioner? I suggest that we may speak of narrative structure in clinical judgement as making reasons available to the agent, where the concept of 'narrative' is to be understood as something fundamentally perspectival.[3]

As noted by Thomas (2005), many theoretical models of value and point of view uses the idea of agent-relative reasons for action to bring out a tacit relativity to the agent's personal point of view in the <u>content</u> of a particular class of reasons or

[3] I use this noncommittal formulation deliberately in order to avoid more theoretically loaded models of the relationship between the normative content of ethics and practical agency, and the general notion of deliberating 'from a perspective'.

values *within* non-perspectival moral reasons or values.[4] However understanding point of view as a determinant of a special class of agent-relative reasons or values contrasted with another class of values or reasons determined by the impartial perspective is entirely optional, and not something that I advocate in medical epistemology. Instead, we may think of point of view as an agent's standpoint on independent ethical reality such that medical judgement identifies something that makes value available *to* an agent's judgement rather than a determinant of value itself.

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[4] The central idea is to establish a contrast between that which is ethically relevant when viewed impartially and that which is ethically relevant from a particular personal perspective. As Dancy (1993, p. 168) puts it, impartial or agent-neutral reasons 'constitute the background against which we are to ask whether there are any other reasons *other than these*.' See also Kagan (1989).

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