

INVITED
COMMENTARY

Clinical judgement and individual patients

INVITED COMMENTARY ON ... IN DEFENCE OF PROFESSIONAL JUDGEMENT[†]

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SUMMARY

Although in agreement with their conclusions about the importance of clinical judgement, this commentary criticises the way that Downie & Macnaughton defend it in their article. I argue that their defence is both overly limited in its account of the role of judgement and that it employs unnecessarily contentious arguments. I outline the ineliminable role that judgement plays in determining which general diagnostic concepts fit individual patients given their individuality and specificity.

DECLARATION OF INTEREST

None.

Like Robin Downie and Jane Macnaughton (2009, this issue), I think that judgement lies at the heart of good clinical practice in psychiatry. But in this commentary I wish to sound a note of caution about their likely success in defending clinical judgement against those who criticise or neglect it. Because their article is intended to be programmatic, I do not wish to criticise it as incomplete (they have written much more elsewhere). My concern is, rather, that their proposed route to a defence of judgement is not the best route, but that there is a better one. Of course, my own brisk criticism and positive outline is even more programmatic.

Downie & Macnaughton suggest that two factors disguise the central role of judgement in good clinical practice. One is the misapplication of numerical codification to judgement based on qualitative research and the other is the rise of a consumer model of healthcare. In this short commentary, I will ignore both the consumer model of healthcare and the idea that qualitative research is connected to clinical judgement. I will focus instead on the brief characterisation of clinical judgement that they offer in the discussion of the latter.

Downie & Macnaughton on judgement

Downie & Macnaughton characterise a central kind of understanding that they think informs

professional judgement and that, for psychiatry, seems to amount to clinical judgement. They write:

[It] is more akin to the understanding gained from literature and art than that gained from a numerical science ... It requires the active participation of readers to identify with the situation and relate the findings to their own situations ... The route to understanding is through our identification with the situation. Through that identification we reach general features of human emotions ... By identifying with a particular situation, the researcher or clinician can recognise the general elements in human emotion ... [E]ven if there is no universality in human emotions and reactions, there is a broad similarity and that may be all that is needed as a basis for individualised judgement.

These comments suggest that the model of judgement that Downie & Macnaughton have in mind is akin to narrative understanding (this is, however, merely my interpretation of their phrase ‘literature and art’; I will return to this at the end); that it turns on general features of human emotion; that it requires that the clinician achieves understanding by identifying with the patient; and that it is a particular kind of individualised judgement.

Especially within mental healthcare, narrative understanding looks to be a genuinely useful addition to criteriological understanding and I agree with the broad thrust of this account (IDGA Workgroup, WPA 2003; Phillips 2005; Thornton 2008a; Thornton 2009). But I have some specific qualms about an account of the wider role of clinical judgement in psychiatry based upon it.

Beyond narrative

First, it would be a mistake to base a defence of the general role of clinical judgement on the need to understand individuals’ mental states in the same meaning-laden terms as are found in literary or narrative forms. As I will outline in the second half of this commentary, judgement has a more fundamental and general role even outside understanding the meanings of people’s experiences and utterances.

[†]See pp. 322–327, this issue.

Judgement in medical science

Second, and related, a restriction of judgement to an understanding of human emotion (however relevant generalities are to be construed) seems misplaced. Both of these leave open the response by what Downie & Macnaughton term a ‘reductionist’ critic (or a more generally biologically minded psychiatrist) that clinical judgement may have a role in the broader surroundings or context of clinical care – in ‘mere’ bedside manner, as it were – but not in the core application of medical science itself. In other words, Downie & Macnaughton do not go far enough in their defence.

Understanding and empathy

Third, it is contentious to claim that, even within the context of a narratively structured understanding of another person’s emotional states, judgement depends on a clinician identifying with a patient. Of course, Jaspers (1913) held that such identification was a central aspect of empathy that was itself at the heart of psychiatric understanding. But, again, as a defence of clinical judgement against a reductionist critic, it ignores the widely influential approach to interpersonal understanding that claims that it is mediated by implicit knowledge of a ‘theory of mind’: the ‘theory theory’ approach. This approach likens an understanding of another person’s mental states to inference to the best explanation and thus, if it were true, would undermine the implicit contrast that Downie & Macnaughton rely on to characterise clinical judgement (in contrast with a scientific or theoretical approach). But even if knowledge of other people’s mental states is not a matter of theoretical inference, it need not depend on identification with them. Why would one need to identify with how things are for another person to understand how they are for them? Why would one need to imagine, for example, being in pain oneself to grasp that another is in pain? Might one not simply see in what they say and do, in what they express, that they are in pain?

Individualised judgement

Fourth, as I have argued elsewhere, it is a grave mistake to think that judgement regarding individual patients requires a form of ‘individualised judgement’ (Thornton 2008a,b). It is indeed tempting to think that clinical judgement concerning particular or individual patients requires a special kind of judgement – one that, for example, rejects general concepts or is independent of more general scientific claims. It lies, I suspect, behind the call for idiographic understanding to complement criteriological diagnosis (IDGA Workgroup, WPA 2003). (Idiographic judgement is supposed to contrast

with general lawlike or nomothetic understanding; Windelband 1980.) However, it raises the question of how any judgement, shorn of potential connections to other patients, can form the basis of a kind of knowledge. Such judgement falls prey to the criticism made by the philosopher Wilfrid Sellars of what he called the ‘myth of the given’ (Sellars 1997). Sellars’ target was the idea that empirical knowledge could be given a sure foundation in direct perceptual reports independent of any uncertain background theory. But, he argued, such reports would need not only to be reliable indicators of whatever features they concerned, but also to be *known* to be reliable. Otherwise they would no more be reports, or judgements, about anything than the reliable squawk of a parrot. That necessary extra knowledge, however, undermines the hope that perceptual reports can be an *independent* foundation for empirical knowledge. To avoid this charge, Downie & Macnaughton may use ‘individualised judgement’ merely to mean a potentially general judgement about a particular or individual situation. As a defence of clinical judgement, however, the phrase is best avoided.

Thus, although I agree with Downie & Macnaughton’s aims, I suspect a successful defence of judgement in clinical practice needs to be both broader and deeper than the approach outlined in their article.

Towards a defence of clinical judgement

Clinical judgement lies at the heart of good clinical practice, in the core application of medical science as well as in the broader context of understanding service users and patients. That, at least, is the claim that needs defence. Here is one way to start to defend it.

From syndromes via symptoms to individuals

Consider the way that criteriological diagnosis is codified in DSM and ICD manuals. Syndromes are described and characterised in terms of disjunctions and conjunctions of symptoms. The symptoms, in recent years, have tended to be described in ways influenced by operationalism and with as little aetiological theory as possible. (That they are neither strictly operationally defined nor strictly aetiological theory-free is irrelevant here.) Thus, one can think of such a manual as providing guidance for, or a justification of, a diagnosis offered by saying that a person has a specific syndrome. Thus, presented with an individual, the diagnosis of a specific syndrome is justified if the person has enough of the relevant symptoms.

The following further thought is tempting. Although the overall syndrome is quite general

and is characterised in a way that abstracts it away from individuals, the specification of why it applies to someone is more specific in two respects. First, because of the way that both ICD and DSM base syndromes on a combination of conjunction and disjunction of symptoms, it is possible that a syndrome so defined may apply to two individuals with little, or even no, overlap of symptoms. The specification of symptoms is thus more tailored to individuals than is the overall syndrome. Second, and independently of that, the heritage of operationalism suggests that individual symptoms are more closely tied (than syndromes) to individuals through a kind of measuring operation. Symptoms seem to tie more abstract syndromes to particular individuals.

The gap between concepts and individuals

There remains, however, a gap between the description or articulation of a symptom and an individual. The concepts of specific symptoms are, despite their specificity, general concepts that can be instantiated in an unlimited number of actual or potential patients. So, how can one judge that a general concept applies to a specific person? One can attempt to bridge this gap. Psychiatry textbooks can describe, rather than merely list, symptoms. But whatever descriptive account they give of symptoms, there will always be a gap between their general descriptions and concepts (which potentially apply to any number of individuals) and any particular individual. Bridging this gap calls for expertise. It calls for a skilled recognitional clinical judgement. In a nutshell, clinical judgement involves skilled coping with individual patients, both the people and their situations, and this requires a kind of non-deductive expertise.

Determinate and reflective judgement

Immanuel Kant was aware of this gap. In his third major work, *Critique of Judgement* (1790), he draws an important distinction between what he calls 'determinate' and 'reflective' judgement. He describes these in this way:

If the universal (the rule, principle, law) is given, then judgment, which subsumes the particular under it, is determinate... But if only the particular is given and judgment has to find the universal for it, then this power is merely reflective. [Kant 1987 reprint: p. 18]

The model at work here is of judgement as having two elements: a general concept and a particular subject. Judgement subsumes a particular under a general concept. The contrast between determinate and reflective judgement is then between an essentially general judgement, when the concept is already given, and a particular or singular judgement, which starts only with a particular.

Determinate judgement appears to be relatively mechanical and thus unproblematic. The idea that if a general principle is already given, then judgements that deploy it are relatively unproblematic can be illustrated through the related case of logical deduction where a general principle is already given. If, for example, one believes that:

- 1 All men are mortal
- 2 Socrates is a man

then it is rational to infer that:

- 3 Socrates is mortal.

One reason that this can seem unproblematic is the following thought. If one has accepted premises 1 and 2 then one has, *ipso facto*, already accepted premise 3. To accept that all men are mortal is to accept that Tom, Dick, Harry and Socrates are mortal. So given 1 and 2, then 3 is no step at all (however, see Carroll 1895 and Fulford 2006). Furthermore, some central forms of deductive judgement, at least, can be codified using Frege's logical notation (Frege 1893). Given the codification, one can inspect the form of a deductive inference to determine whether true premises could ever lead to a false conclusion. (In fact, neither of these reasons for taking deduction, and thus determinate judgement, is quite so straightforward. Here, however, the perceived relative straightforward nature of determinate judgement is what matters.)

By contrast, for reflective judgement, there is a principled problem in how to get from the level of individuals to the level of generalities, or how to get from people and things to the general concepts that apply to them. That is not a matter of deduction, because the choice of a general concept is precisely what is in question. To move from the particular to the general that applies to it is somehow to gain information, not to deploy it. Reflective judgement thus cannot be a matter of mechanical derivation.

The art of judgement?

Kant himself suggests that there is a connection between reflective judgement and aesthetic understanding. The art of judgement, he thought, could be informed by judgement of art. Thus, for example, the way a viewer makes sense of, and sees a unity in, a Jackson Pollock painting, may shed light on how one can be guided, in advance of knowing the relevant concept, as to which concept applies to an individual person (Bell 1987). It may be this connection to which Downie & Macnaughton are referring when they talk of clinical judgement as being connected to judgements of literature and art (to which I promised to return). Whereas this is still an open philosophical issue, there is reason to

think that art cannot provide a substantial clue to further unpack the nature of the expertise involved in judgement (Thornton 2007).

But what is important about Kant's account and the illustration of it in the case of psychiatric syndromes and symptoms is that it demonstrates how such judgement is always involved in the application of general knowledge to individuals. Whatever general claims can be gained from quantitative research – which lies at the heart of evidence-based medicine – their application to individuals necessarily depends on a kind of skilled expertise in judgement. This does not merely apply to understanding the psychological aspects of service users or patients (hugely important though that is). Even in judgements that are seen as paradigmatically empirical and scientific, skilled and uncodified expertise, or clinical judgement, lies at the heart of seeing that a general concept applies to an individual person.

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