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**Narrative Understanding, Value and Diagnosis: A Particularist Account of
Clinical Formulations and Shared Decision-Making in Mental Health**

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Abstract: In this article, I deploy the notions of narrative and discernment as complementary support tools in understanding the moral significance of the first-person perspective in mental health. My aim is to develop and extend moral particularism's emphasis on the significance of context and the general problem of relevance in understanding the dynamics of practical judgement and shared decision-making as applied to comprehensive diagnosis and integrated treatment. I argue that it is a mistake to think of the values embedded in responsible integrated care and patient involvement as *either* determined by the individual patient's autobiographical narrative *or* as determined by the 'top-down' conception of health as presented in the biomedical model. What is missing in accounting for the idea of clinical decision-making as a *shared* enterprise is a relational account of the person and the wider diagnostic treatment context in understanding the process of perspective-taking. Such reorientation of focus makes available a distinctive conception of clinical knowledge, in which claims to objective meaning in patient narratives are criticised not as false *per se*, but as failing to yield the insight into the problem it was the point of those claims to provide.

1. Introduction

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 particular decisions count as right or wrong, just or unjust, virtuous or vicious. Medical ethics has been dominated by principlism. However, so-called moral particularists have forcefully attacked the dominance of principle-based normative theories (see Dancy, *passim*; Smith, 2010; Thomas, 2006). The particularist critique of traditional moral theory (applicable in both bioethics and clinical understanding) derives from the rejection of the claim that the normative content of ethics and medical discourse be specifiable *in vacuo* independently of concrete circumstances of assessment and choice. Particularists hold that responsible moral thought and judgment does not require a suitable supply of general principles that can serve as a premise for the conclusion in an inference, whether explicitly or implicitly and no matter how sensitively done. Instead, and this is the central positive claim about moral understanding, practical moral knowledge is a form of knowledge that results from the successful exercise of *discernment* in particular contexts of evaluative appraisal. This having been said, it is also worth noting that there is no settled view of characterising particularism. This is partly because the approach comprises a variety of considerations about the structure of morality and evaluative thought; it has been described as a family of doctrines united by a critical attitude to the role and nature of general principles, ‘more a sort of suspicion rather than a thesis’ (Dancy, 2008: 3), challenging certain orthodox foundational presuppositions about what morality must be like for the very possibility of normativity in making moral distinctions and, indeed, the practical application of such distinctions (in bioethics and beyond).

Jonathan Dancy’s influential developments of moral particularism and those influenced by it (for example McKeever and Ridge, 2005) have stressed that the approach

is a general philosophical thesis about the ‘metaphysics of reasons’ (Dancy, 2004) in metaethics, philosophy of normativity, philosophy of action and beyond. Philosophers like Jonathan Dancy think that it is possible for more or less any consideration to provide a reason for some action or attitude in some contexts, but to provide a reason against it in other contexts and no reasons either way in yet others. This is their “holism” about reasons (Dancy, 2004). Others have instead aligned the approach with epistemic and semantic contextualism (Lance and Little, 2004; Thomas, 2005; ANONYMIZED) and moral epistemology (John McDowell, *passim*; Benedict Smith, 2011; Lance and Little, 2008).

In this article, I will take a step back from the currently entrenched debates about the metaphysics of reasons in the particularist-generalist literature about holism and consider the deeper question of what it is for serious practical reflection to constitute knowledge, and what ‘responsiveness to reasons’ in clinical practice can generally be taken to consist of. In my estimate, this is what particularism needs if it is to serve as an adequate and substantial position to complement evidence-based medicine (EBM) in clinical understanding.ⁱ My overall aim is to demonstrate the wider reach of the concepts of moral perception and discernment as applied to psychiatric diagnosis and integrated treatment as a way of understanding the moral significance of the first-person perspective in mental health contexts. The novelty of my approach consists in maintaining a **non-relativistic realist** ethical and clinical stance toward patient narratives that preserves the value of such narratives in the clinical decision-making process, while also recognising that there are ways in which such first-person points of view may be difficult to understand and even inaccurate with regard to the patient’s own history.

The general methodological challenge that particularism poses in ethics parallels recent developments in discussions about values and clinical judgement in medical epistemology (what I have also referred to as ‘clinical understanding’).ⁱⁱ In particular, the so-called ‘biomedical model’ implied by the evidence-based medical paradigm has made

significant 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; Sackett et al, 2000). These developments are often accompanied by a renewed interest in narrative (Charon, 2006; Charon et al, 2008) and casuistry (Jonsen and Toulmin, 2014; Strong, 1998) and other attributes of a whole, integrated decision-maker. Indeed, as Sackett (2000) himself makes clear, clinicians must utilize other forms of medical knowledge, including clinical experience, in order to arrive at the best medical decision for a particular patient. On my account of these integrated models, it would be a mistake to construe the idea of “expert opinion” merely as the provision of medical information from a clinical stance that Anna Freud once identified with “clear objectivity” and an “absence of bias” (1936: 28-29), rather than through the lens of his or her own value commitments. While in my view doctors (no less than patients) cannot really avoid making value judgements in clinical contexts as historical persons, patient narratives may also be difficult to understand because patients do not necessarily have either fixed or transparent values and can also make inaccurate choices with regard to their own values (*e.g.*, because of a lack of self-worth and other psychological processes such as failure of self-empathy). Given these complications in moving from general research evidence to particular diagnostic treatment, and the growing recognition that clinical decision-making is a shared and value-laden enterprise, there is the further question about the *sources* of normativity.ⁱⁱⁱ

Consider, for example, E.D. Pellegrino’s (1999: 55) seminal teleological account of normativity in medicine and shared decision-making. Pellegrino sets up the following dilemma: either the ends and norms of medicine are “internal” to medicine itself or they are set “externally” by some form of *construction*, relative to the values of a culture, place or time in history. However, as Ben-Moshe (2017) notes, given that societal values and norms can in fact be underpinned by external *universal* moral frameworks such as utilitarianism or

Kantianism, the choice between cultural relativism and Pellegrino's moral internalism is clearly false. Thus, for example, on Beauchamp's (2001) influential principlist account of bioethics, the normativity inherent to clinical practice is precisely derived from more general external moral principles (such as the moral principle autonomy). 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 judgement can consist in – after all, particularism rules out some of the most popular answers given by traditional universalist ethical theories and thereby forces us to widen the spectrum of possible answers.

Proponents of EBM and traditional bioethics of course recognize the need to 'integrate' specific features of cases into clinical reasoning. Still, much work remains to be done at the theoretical level on this issue. I maintain that there is good reason to think that the sharp contrast between the so-called 'biomedical model' and patient-centred narratives is the wrong place to start in understanding the putative significance of the first-person perspective in clinical understanding. After all, most population based clinical research (such as randomized clinical trials) is concerned with treatment outcomes, and not primarily with the meaning of symptoms or signs that are at play in individual patient narratives. Positioning them in opposition to one another only encourages an unfortunate dichotomous classification of methods where narrative is cast as the "art" of clinical knowledge and the biomedical model is cast as "science". As Miriam Solomon notes, such a dualism not only obscures 'an underlying, richer, pluralism' of methods in clinical practice, but it also implies a misleading conception of science as somehow devoid of narrative techniques, something that is plainly false (2015, p. 179). A closer examination of actual clinical practice shows that 'narratives are a common form in which we discover, state and reason about causal connections', in a way that mitigates against viewing narrative reasoning as having a '*sui generis* narrative logic wholly different and divorced from causal

conditions and logic.’ (ibid.). Solomon’s analysis seems to me correct as far as it goes: the use of narrative in medical contexts in engaging with patients as persons is unhelpfully contrasted with our ordinary ways of making sense of causal connections in the world. The deeper issue as I see it is how complementary models might influence the epistemology of clinical expertise in understanding diagnosis and clinical decision-making.

A significant aspect of the renewed interest in patient-centred narratives in clinical understanding is a humanistic concern for integrated care and intersubjective empathy in the therapeutic encounter in order to understand the patient’s experience of illness (and wellbeing). Such understanding is important for providing effective treatment and management, and to reduce suffering and loneliness (Carel, 2008; Toombs, 1992). Empathy is sometimes characterised as a narrative competence because narrative is directed at the first-personal dimension of the patient’s experience in interpersonal clinical encounters. Thus, one might be tempted to cast the difference between traditional biomedical diagnostic approaches and narrative particularistic models as a choice between focussing whether one focusses on *either* the general scientific evidence *or* the particular patient’s point of view. I will argue that such a division would be a mistake; my account of the epistemological issues concerning patients’ narratives and clinical judgement is meant to speak to the functioning of discernment and practical judgement in clinical understanding more generally.

What counts for the “particularity” of discernment as a clinical skill on my approach instead concerns the *methodology* of good clinical practice and what we may think of as a “no-priority” view inspired by new work on the concept of *shared decision-making* as a relational process of integrating the best evidence (what works best), professional experience and stakeholder values, established through dialogue. I will show how a methodological particularist account based on discernment can incorporate patient values internal to the *normative* gold standard of shared decision making in understanding

the *ethos* of good medicine, rather than treating patient values as something that must be reconciled with an ‘objective’ medical diagnostic approach in meeting the gold standard (as in the work of Franklin Miller and Howard Brody on assisted suicide (Miller and Brody, 1995) and managed care (Miller and Brody, 1998).

Following Nir Ben-Moshe (2017), I argue that the proper source of normativity in clinical practice is internal to a positive procedure that would satisfactorily incorporate the patient voice. As Ben-Moshe (2017: 1) puts it, ‘patients should be involved in the construction of medicine’s morality not only because they have knowledge that is relevant to the internal morality of medicine—namely, their own values and preferences—but also because medicine is an inherently *relational* enterprise: in medicine the relationship between physician and patient is a constitutive component of the craft itself.’ This, I maintain, is also the key normative element of the shared decision-making model that requires clinicians to make value judgements with the active participation of the patient in dialogue: the sources of normativity are internal to the dynamic process of interaction with patients, where the interaction between patients and clinicians is understood *relationally* as an open-ended process of perspective-taking informed by the wider treatment context (for additional historically influential statements of internalism and externalism of medical normativity in bioethics, see Ladd, 1983; Beauchamp, 2001; Pellegrino, *passim*).

Where I break from Ben-Moshe is in my standing (not here argued for) commitment to moral realism rather than moral constructivism in understanding the central internal normative requirement of shared decision-making as the gold standard for medicine. The mistake, I argue, is to think that a commitment to moral realism implies a commitment to *stance-independent* views of ‘objectivity’ in bioethics (as in Pellegrino, 1999; 2001a; 2001b) and philosophy of science more generally as the only option in understanding the idea of mind-independent value in good medical practice. Instead, we

may follow Arthur Fine's (1986) account of epistemic validity in philosophy of science more generally and think of discernment in relational terms such that there is no "outside" in shared decision making, a claim I return to below (Section 3).^{iv}

To defend this claim, I will sketch an alternative model that builds on recent work on the notion of narrative idiographic understanding in psychiatric diagnosis (IDGA Workgroup, World Psychiatric Association, 2003). On my account of discernment in idiographic judgement (understanding a phenomenon or event as a singularity instead of rule-bound) as a tool for clinical understanding, the relevant sense of 'narrative' is treated as a pre-reflective structural ability in interpersonal discourse, a transcendental condition for reflective self-awareness, if you like, as opposed to a constitutive feature of value itself. I also show how discernment as a clinical skill is informed by a vision of relationality in speaker *uptake*" (Austin, 1975; Nyqvist Potter, 2016 and 2019) in our capacity to talk together in understanding the reality of the particular historical other in shared concept application, in a way that poses no threat to the idea of objectivity in clinical practice or the metaphysics of values. This, I will argue, brings into view a new perspective on shared decision-making distinctive of my novel articulation of particularism as a general model of the *ethos* of good clinical practice.

2. Preliminaries and The Way Ahead

The acknowledgement of medicine as a normative practice (as opposed to mere opinion) has led to the idea of shared decision-making as the gold standard for clinical practice, a model that reintroduced the need for clinicians to make value judgements *together* with their patients in the interactive process of treatment established through dialogue. In what follows, I develop the positive claim that clinical judgement is not mere opinion, but is constrained or determined by what it is right to say *within* the interactive process of

diagnosis and treatment that arises between patient and clinician given the treatment context. Along the way, I draw out the implications of this view for the possibility of a value objectivism, which is implicit in many contemporary debates about normativity as internal morality integral to a value-laden conception of medicine.

I begin (Section 3) by discussing the concept of idiographic understanding (the idea of understanding a phenomenon or event as a singularity instead of rule-governed) in psychiatric diagnosis and a general problem with particular knowledge, namely the concern that idiographic judgement (the idea of understanding a phenomenon or event as a singularity instead of rule-governed) and, by implication, contextual discernment reduces down to a form of epistemic atomism and what Thornton (2010) calls “individualised judgement of particulars”. Focussing on idiographic formulation in psychiatric diagnosis, I suggest that we can develop the view by problematizing the underlying concepts of ‘context’ and ‘point of view’ in understanding the complexity of the epistemology of clinical expertise in the therapeutic encounter.

The upshot of this discussion of point of view raises the explanatory desiderata for Section 4: how to understand first-personal thinking in relation to the general problem of relevance in clinical practice. Through the use of examples, I argue that we need narrative reasoning to settle what answerable stance the agent is *reasonably* taken to express in using general concepts.

In section 5, I develop the particularist model of narrative structure, arguing for a notion of correctness as not limited to an individual person’s perspective but also shaped by the contextual parameters of the treatment context.

Finally, in Section 6, I discuss the difference between the first- and second-personal perspectives on experience in interpersonal empathetic engagement, and how this bears on the issues of objectivity and critical evaluation. I end with some concluding remarks

about the wider significance of the role played by discernment in understanding internal normativity as a model of shared decision-making in clinical practice.

3. Idiographic understanding and the problem of epistemic atomism

It has been known for some time that however plausible a view particularism may be in ethics, it requires a robust supporting epistemology if it is to be an adequate and substantial position, capable of meeting the barrage of objections it is receiving (Hooker and Little, 2000; Lance, Potrc and Strahovnik, 2006). One worry about a particularist account of moral or scientific thought has been precisely that it seems to anchor moral and epistemic reasons, and thereby the judgement based on those reasons, so deeply in the details of particular situations that it is difficult to see how someone who counts as a competent judge by particularist lights will be able to reliably project their understanding to new sorts of situations.^{vi} Focussing on idiographic understanding in psychiatric diagnosis, I suggest that we can develop the view by problematizing the underlying concepts of ‘context’ and ‘point of view’ in understanding the complexity of the epistemology of clinical expertise in the clinical encounter.

Idiographic understanding aims to capture the significance of the individual person’s point of view, and is sometimes identified with descriptive narrative formulations in comprehensive psychiatric diagnosis (Philips, 2005; Mezzich, 2005; Mezzich et al, 2011). As Phillips (2005) puts it, ‘a *narrative or idiographic* formulation is an individual account with first-person and third-person aspects. That is, the patient tells her/his story, with its admixture of personal memories, events and symptoms, and the story is re-told by the clinician.’ (2005, p. 182). How are we to understand this?

As intimated in the introduction, there has been a tendency to treat the experience of the patient as the ‘subjective’ polar opposite to that of ‘objective’ general nomological

diagnostic standards such as the *International Classification of Diseases* or, in the context of mental health, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in the literature about the idiographic formulation in psychiatric diagnosis. Thus, for instance, while being sympathetic to the idiographic formulation in psychiatric diagnosis and the general notion of particularism in clinical practice, Thornton (2010) argues that placing too much emphasis on the particularities of individual circumstances at the expense of statistical generalities in psychiatric diagnosis would seem to generate a kind of epistemic atomism.

The objection from epistemic atomism is the concern that the resulting clinical judgement is epistemically independent of all other judgements, in which case the very status of idiographic judgement as a *judgement* is threatened (if by ‘judgement’ we mean something that expresses a propositional content that can qualify as either true or false). To avoid this problem, Thornton (2010) argues for a narrative formulation of idiographic understanding to complement the criteriological approach in comprehensive diagnosis based on a *normative* conception of reasonableness and inter-personal dialogue in natural language (as contrasted what is statistically usual).

At this juncture, one may wonder what is being opposed to what. Thornton’s negative argument against idiographic judgement is based on Wilfrid Sellars’ (1997) and John McDowell’s (1994) arguments in philosophy of language that for a judgement to qualify for assessment pertaining to truth, its propositional content must refer to conceptually explicable truth conditions. I hold that that the initial objection, motivated by Thornton’s construal of the concept of idiographic judgement as ‘individualised judgement of particulars’ (Thornton, 2010: 261), is based on a misconception of the idiographic formulation in psychiatric diagnosis. Thornton may be right that merely reporting information on circumstantial conditions about the individual that has no bearing on standardised information raises a host of reliability problems. But there is no good reason

to regard idiographic judgment as a matter of isolated or “individualised” judgement of particulars in the first place. The reason, I maintain, is that the test for validity of narrative formulations is always already *framed* by the use of shared general concepts (such as *depression* or *emotional dysregulation*). Such general concepts carry with them particular ways of making rational sense of what a patient says, in a way that has to answer both to the contextual parameters of the individual person’s life-world and to a broader structure of rationality as a *continuous* critical scrutiny (Thornton, 2007: 200-201).

To see how this discernment model might work in practice, I find it helpful to explore the use of autobiographical narrative in therapeutic contexts as a tool for self-transformation and positive change. Consider the issue of defiance in psychiatric engagement in dealing with ‘difficult patient’. The psychotherapist Lauren Slater tells the story of Marie, a clinically depressed person in remission described as *numb* and *paralysed* by her condition. Commenting on Slater’s (1997), Nyquist Potter (2016: 67-70) draws our attention to the ethical significance of Marie, a patient who occasionally self-medicates with recreational drugs, convinced that no one and nothing can help her. She accidentally takes an over-dose of heroin and, once hospitalised again, actively and passionately refuses to attend social group activities in line with staff expectations; although this violates the prescribed norms of her ongoing systemic therapeutic treatment plan, Marie is adamant on staying in her room (except for spending hours in the toilet weeping in *despair*). Slater, Marie’s therapist, later reflects on her own reaction to the complex situation with the person in her care:

I was actually pleased to hear about Marie’s refusal to go to groups. It spoke of some spark of anger, some spot still scarlet within her. When I heard that, I got yet

another glimpse of Marie, this time not joyful, not flattened by grief, but lit red in her rage. (Slater: 1997: 127)

In the memoir that the clinician Lauren Slater narrates about her patient, one can detect empathy in Marie's stance of being isolated from others, and one also gets the sense that the author regards herself as being called to break the isolation in reflecting on the *reasonableness* of Marie's refusal to act according to staff expectations and the social norms of the hospital ward. Nyquist Potter suggests that through Slater's use of concepts such as 'spark of anger' and 'lit red in her rage' to understand Marie's first-personal point of view, she blurs the distinction between the clinical sense of *refusing treatment* and the expression of *appropriately defiant* acts. Moreover, in characterising Marie's new position in expressing anger in this way, Nyquist Potter interprets the therapist as also exploring possible trajectories of their working alliance in moving forward (2016: 68).

To make progress, more work is needed in elucidating the central concepts of *perspective* or *point of view* in the debate over the role of narrative in psychiatric diagnosis and treatment. As noted by Posborg Michelsen (2013) the emphasis on narrative idiographic understanding within the *Institutional Program on Psychiatry for the Person* (IPPP) and the *International Guidelines for Diagnostic Assessment* (IGDA) masks an ambiguity concerning the use of the terms 'contextualisation' and 'context of the patient' that prompts further questioning. We may either understand the idiographic diagnostic formulation as the claim that context-specific information about the individual should *complement* the standardised statistical information, or else understand it as the claim that the context of the individual patient can somehow *alter* the conception of the standardised information itself (Posborg Michelsen, 2013, p. 73). Thornton seems to work with the former conception of idiographic judgement, criticising it for being too isolated and local, whereas the emphasis

on what Mezzich et al (2011) call a ‘multi-perspectual analysis’ in diagnosis within values-based practice appears to suggest a contextualisation of the *concept* of mental illness itself rather than a mere addition to a standardised criteriological diagnostic understanding. Both conceptions face problems, and this is not the place to settle the debate. Instead, I will defend the alternative and novel positive suggestion that we re-think the idea of the “point of view” of the individual patient and the wider context of the treatment situation as something that makes relevant facts available *to* the practitioner’s clinical judgement (as opposed to being a determinant of meaning as such). How should we understand this?

Rather than eschewing the idea of objectivity (in ways that rejecting the idea of genuine moral conflicts may imply), I maintain that the idea of ‘getting your descriptions right’ is better framed as having a critical openness to alternative ways of understanding the stance of others in the application of shared concepts in clinical practice. There are two claims in this characterisation of discernment as a standard of correctness in the interactive model of shared decision-making. First, my notion of *critical openness* in perspective-taking involves commitment to a notion of moral salience in clinical understanding as a normative notion, as opposed to its psychological counterpart that is implied when we are merely interested in what, as a matter of fact, the agent takes as salient in the particular situation. As Dancy once put it in a discussion of so-called thick evaluative concepts, ‘the account is normative in style, since it *requires us to act* in certain ways rather than others’, namely in ways that are merited in the ‘normative light’ cast by (shaped up) facts of particular cases (Dancy, 2004: 197, my emphasis). Secondly, the implied allusion to the ‘context’ of particular cases is here understood to include the wider social and professional dimensions of the treatment setting. Accordingly, understanding an individual point of view is not necessarily determined by what the patient means (or implies) ‘subjectively’. It is also normatively constrained by contextual parameters of the treatment

process, where finding the appropriate parameters takes place in the interaction between patients and clinicians in their settings.

Settling the treatment outcome in isolation from what I will later (Section 5) refer to as the normative practical context of the person's life-world and the wider parameters of the treatment context not only fails to acknowledge part of the patient's suffering, because in ignoring the shape of one's life-world, an important aspect of the first-personal sense of the object's status of *being understood as a person* may also be undermined. The importance of the patient's status of being understood (or not) speaks directly, I maintain, to a key motivation for thinking of narrative as tool for the development of a positive therapeutic relationship in a context of trust and, where necessary, empowerment for positive change.

So far, I have argued that Thornton's objection to the idiographic judgement in comprehensive psychiatric diagnosis from epistemic atomism is unmotivated. The real question as I see it, and to which I turn in the following section, is the practical problem of determining *which* answerable stance is operative in the interactive use of shared general concepts such as 'depression' in idiographic formulations.

4. Narrative formulations and the problem of relevance

I suggested above that what makes the slide from patient values and shared-decision making to both value relativism and value constructivism seem tempting (as in Ben-Moshe, 2017) is the implicit mistaken assumption that realist arguments about clinical understanding must be construed from a perspective *outside* clinical practice. Rather than thinking of narrative in this way, John McDowell suggests a new test of narrative validity as determined from within an engaged scientific practice. He writes:

Like any thinking, [narrative] thinking is under a standing obligation to reflect about and criticise the standards by which, at any time, it takes itself to be governed. [...] Now, it is a key point that for such reflective criticism, the appropriate image is Neurath's, in which a sailor overhauls his ship while still afloat. This does not mean such reflection cannot be radical. One can find oneself called on to jettison parts of one's inherited ways of thinking; and, though this is harder to place in Neurath's image, weaknesses that reflection discloses in inherited ways of thinking can dictate the formation of new concepts and conceptions. But the essential thing is that one can reflect only from the midst of the way of thinking one is reflecting about. (McDowell, 1994: 81).

Thus, on this view, while the test for validity in narrative formulation is in the end a matter of judgement it is nonetheless a judgement made against general patterns of what makes *rational* sense from within an engaged practice – and all such concepts are continuously subject to critical scrutiny from the 'space of reasons' (John McDowell, 1994) alluded to before. To see this, we may follow Arthur Fine's (1986) discussion of adopting a 'natural ontological attitude' in the domain of philosophy of science. Fine writes:

The realist, as it were, tries to stand outside the arena watching the ongoing game [of science] and then tries to judge (from this external point of view) what the point is. It is, he says, about some area external to the game. The realist, I think, is fooling himself. For he cannot (really!) stand outside the arena, nor can he survey some area off the playing field and mark it out as what the game is about. (Fine, 1986: 131).

Although Fine argues against traditional epistemological realism, he also does not support a form of epistemological anti-realism. The claim is rather that the reasoning motivating *both* the traditional realist attempt to validate scientific reasoning *and* anti-realist efforts at undermining it fail, since it is impossible to take the sort of external perspective in science that these arguments seem to require. It is also worth noting analogous methodological developments in prominent strains of social epistemology in philosophy of science, which seek to integrate descriptive modalities found in sociology and anthropology into the study of science more generally. Indeed, as Holman *et al* note, a central reason philosophers such as Goldman (1999), Solomon (2001) and Longino (1990) endorse the methodological reliance on detailed case studies (a focus on the particular) in philosophy is their acknowledgment ‘that traditional approaches to philosophy of science were not well-grounded in the realities of scientific inquiry’ (2018).

What determines, for a given patient narrative, whether something is a salient or relevant possibility? I come back to that question below (Section 4). Here I just want to note that the central issue on my account of the narrative formulation is not so much the problem of formulating appropriate conditions for epistemic filtering (see Hintikka (2007) and Lewis (1996) whereby some, but not all, possibilities are properly ignored), as the question of what Travis (2008) refers to as *occasion sensitivity* in determining which salient answerable stance the subject expresses in using the relevant general concept.

Notice that this aspect of the positive account is in principle fully compatible with Thornton’s use of McDowell’s epistemological arguments that propositional content must refer to conceptually explicable truth conditions. Posborg Michelsen’s central point, in response to Thornton, is that a concept’s *conditions of application* may vary from context to context (and in this sense generate “individualised” narrative judgements in speaking about depression in consultation on particular occasions), in a way that does not affect the general

truth conditions for the target concept itself. In other words, even if we grant the claim that there may be an indefinite number of more precise ways to satisfy the truth condition for the general concept of depression, contextually salient ways of counting as *depressed* on some occasions but not others, the mere fact that there may be indefinite ways to satisfy the truth condition in question need not mean that it is not a genuine truth condition prior to such pre-specification. As we have seen in the use of examples, what my position adds to this general observation is the substantive claim that narrative or idiographic judgement is required to determine a *unique* content in linguistic representation and thought. I hold that there is an irreducibly normative aspect of the concept of relevance that is often overlooked in the debate over contextualism in the literature as applied to clinical understanding. On my view, we need discernment to settle what answerable stance the agent is *reasonably* taken to express in using the concept in question in the circumstances. In this sense, then, knowledge of relevance in idiographic understanding belongs to the epistemology of the normative. What characterises such a stance?

One option is to follow Ben-Moshe's constructivist account of medicine as a value-laden enterprise. On this view, shared decision-making is achieved through an interactive dialogue where doctors are considered the clinical experts on how conflicting treatment outcomes will impact the patient, and the patient the knowledge of the degree to which they value those outcomes. As Ben-Moshe puts it, although the 'physician might be the expert when it comes to the patient's medical good, it is the patient who has intimate knowledge of his perception of the good' (2017: 15). Nevertheless, the decision is yet both shared and internal to medicine because it is only through the discussion between the doctor and the patient that the proper treatment outcome can be (jointly) determined; the outcome does not stand apart from the clinical process, but is constitutive of it.

While there is much that I admire in Ben-Moshe's account of internal morality in medicine, my preferred particularist account works with a stronger realist notion of 'value' than the idiosyncratic discernment of personal rankings of preferences. To make this option visible, I will articulate my novel view of narrative structure in clinical judgement as making certain reasons available to the agent, where the concept of 'narrative' is to be understood as an interactive process of perspective-taking between patients and clinicians shaped by their treatment setting. I use this noncommittal formulation deliberately in order to avoid commitment to more theoretically loaded accounts of the relationship between the normative content of ethics (and medical discourse) and practical agency, and the general notion of deliberating 'from a personal point of view' in shared decision making. A familiar representative theoretical model of the relation between the moral agent and ethical values uses the idea of agent-neutral reasons for action. This is a standard way of understanding the idea that a reason stands in a special relation to a particular agent or class of agents (see Nagel, 1986). It is a model of agent-relative value that also seems to inform Ben-Moshe's contrast between a clinical opinion about a patient's medical good and the idea of patient values as an individual's "perception of the good". However, understanding the general notion of *point of view* in shared decision-making as a determinant of a special class of agent-relative reasons or values that contrasts with another class of values or reasons determined by the impartial perspective is entirely optional. Instead, we may think of *point of view* as an agent's standpoint on independent reality (evaluative or otherwise) such that medical judgement identifies something that makes value available *to* an agent's judgement rather than being a determinant of value itself (Thomas, 2005). As far as I know, this possibility has never been considered in articulating the theoretical commitments of particularism in relation to the idiographic formulation of psychiatric diagnosis.

As mentioned before, where I break from Ben-Moshe is in my standing (not here argued for) commitment to moral realism in understanding the central concept of *point of view* and perspective-taking in the model of decision-making as the gold standard for medicine. The mistake, I submit, is to think that a commitment to moral realism implies a commitment to *stance-independent* views of ‘objectivity’ in bioethics (as in Pellegrino, *passim*) and philosophy of science more generally as the only option in understanding the idea of mind-independent value in good medical practice. Instead, we may think of discernment in relational terms such that there is no “outside” in the application of shared concepts in clinical practice.

Now, according to intersubjectivity theorists like Chris Jaenicke (2008) and Donna Orange (2002), there are two parts to the implicit corollary that there ‘is no outside’ in understanding normativity in medicine. The first claim is an epistemic ‘no priority’ claim about knowledge in intersubjective empathetic inquiry, such that neither perspective of the parties involved in the therapeutic relationship is prioritised over the other. On this view, therapeutic inquiry does not assume that the clinician’s perspective is more apt than the patient’s or that we can directly know the perspective of the patient. As Stolorow expresses the point in psychoanalytic psychotherapy research, we can only ‘approximate this reality [of the other] from within the particularized scope of the analyst’s own perspective (Stolorow 1999: 385). The second claim is a claim about the meaning of individual concepts as a function of the wider interpersonal systems in which they operate (in psychoanalytic discourse and beyond). For psychotherapist Donna Orange (who defends a version of *constructive* internal realism), the core problem with failing to recognise the normativity of concepts in their contexts is that we may mistakenly come to believe that it *is* possible to describe, context-free, ‘what the patient is doing to me, or I to the patient, as if one or both of us could momentarily stand outside the system that we constitute together’ in the psychoanalytic process (Orange 2002: 698). On this view, then, there is no

such thing as a ‘patient’ *in vacuo*; ‘there is only a patient within the context of the analyst’s care, and conversely there is no such thing as an analyst, but only an analyst for and with this particular patient’ (ibid.). Each of those perspectives may be more or less appropriate, depending on the task at hand.

Where I differ from Orange, Stolorow and Jaenicke is in my denial that the emphasis on perspective and point-of-view in shared decision-making commits us to constructivism rather than realism in understanding the nature of meaning and value itself. On the one hand, we need to be careful not to confuse the general idea of upholding some notion of “clinical expertise” (which some argue involves a prerequisite asymmetry between the clinician and the patient in the therapeutic relationship; see Jaenicke 2008: 14) with a misguided idea of neutrality. On the other hand, we must also recognise the challenges that the necessity of relatedness places on individuals within the clinical commitment to the therapeutic endeavour for positive change.

To illustrate, consider a case where a patient who has experienced accumulative trauma such as abuse and childhood emotional neglect (CEN) is encouraged to become increasingly vulnerable in the clinical therapeutic relationship to bring to awareness compartmentalised or disavowed patterns of thinking and feeling. Suppose further that practising awareness of the original injunctions can serve to practise the conditions for positive change in dealing with current experiences in a more flexible and spontaneous way. Imagine further that the therapist finds the exposed material so traumatic, painful, dangerous or otherwise inappropriate that they (knowingly or not) withdraw from the empathetic exploration. Indeed, as Erskine, Moursund, and Trautmann (1999) note, one of the challenges in the process of integrative *corrective* therapeutic intervention with persons who have experienced trauma or neglect is that the therapist may move too quickly to problem-solving or do too much in simulating the hurt, the fear, and defences of the

original injunction; '[s]ometimes we become impatient, we press ahead too quickly, or we insist on behavioural changes without sufficient inquiry into the important protective function of the old patterns' (1999: 14). Given such circumstances, it is not unreasonable to suppose that the patient may be re-traumatised from the therapeutic interaction ("If even my therapist can't tolerate my feelings..."), in which case the encouragement to vulnerability in exploring integrated, typically not endorsed, patterns of thinking and feeling would be counterproductive in psychological terms from the patient's perspective. (See, e.g., Kohut, 1977; Safran *et al*, 1990; Erskine, Moursund & Trautmann, 1999; Jaenicke, 2007). Or suppose that a hypochondriac patient presents with severe anxiety of developing mental illness. Paradoxically, telling the patient that she manifests signs of hypochondria, thus understood as a mild form of psychopathology, in the light of such anxiety could be detrimental to her mental wellbeing.^{vii}

Now, the problem with the treatment outcome in these cases need not be seen as an objection to the 'biomedical model' as such; it need not undermine the general claim of the American Psychiatric Association (APA, 2001) that psychotherapy is the primary treatment for post-traumatic stress disorder (PTSD) or personality difficulties (or 'personality disorder', PD), for instance. The claim is rather that the practical shape of one's life as a person matters in settling the *normative* question as to which mode of treatment is appropriate in a given case to avoid re-traumatization in exploring protective, but ultimately unhelpful, patterns of response. Moreover, and this is the deeper issue as I see it in capturing the significance of the first-person perspective in clinical practice, to see the suffering of the patient as a survivor of trauma or neglect is part of acknowledging the normative practical shape of the *person* as such. Determining how sensitive a patient is to any hint of threat, and the level of negative orientation in expectations and accompanying performance standards, for example, are often important cues to what have may have happened or have been imagined in the past. This, in turn, can help elucidate the patient's

agentic orientation as a historical person.

So how are we to understand this contrast between the present model of narrative understanding and the constructivist model of value and selfhood that is sometimes implied in discussions of narrative more generally? Let us return to the idea of narrative structure in discernment as a clinical skill.

5. Particularist Epistemology and Narrative Structure

Let us take stock. On a particularist model of explanation and evaluation, to explain what it means for a feature to function as a reason (for belief or for action) *in situ* requires more than simply asserting that the fact in question *obtains*. This would follow immediately from the holistic claim about reasons that there is nothing *intrinsic* about any feature, which makes it a reason in that particular case or *in vacuo*. Hence, if the particularist is right, the feature may well obtain and yet not function as a reason in the particular case at hand. Rather, the judgement is merited by how this fact *ought reasonably be taken* in the particular context of appraisal, where finding the range of possible, reasonable answers occurs in the interactive process between the patient and the clinician and the wider context of diagnosis and treatment; this is the *normative* fact of the matter. John McDowell offers the following example of pattern-recognition to illustrate the central positive claim. He writes:

In a schematic picture of a face, it may be the curve of the mouth that makes it right to say the face is cheerful. In another picture the mouth may be represented by a perfect replica of the line that represents the mouth in the first picture, although the face is not cheerful. Do we need a relation of defeasible support in order to accommodate this possibility? Surely not. What is in question is the relation of ‘making it right to say’; it holds in the first case and not in the second. Since the

relation does not hold in the second case, it cannot be understood in terms of entailment. But why suppose the only alternative is defeasible support? (McDowell 1998, p. 378).

This example illustrates a by now familiar notion associated with particularism: that the normative (or reason-giving) status, if there is such, of a given consideration is determined by the context in which it is embedded. Everyone can agree that a feature's reason-giving force – its *critical support* – depends upon context. The key question is *how* context enters into the equation. One option, as we saw in the discussion of idiographic understanding in psychiatric diagnosis earlier, is to adopt the epistemic contextualist view and say that a concept's *standards of application* can vary depending on the circumstances, where the role of context is to provide an *epistemic filter* whereby some, but not all, possibilities can be properly ignored. This is a standard way in which the problem of relevance has been understood and fits well with the orthodox view of criteria as defeasible reasons. What more needs to be said?

One thing that needs to be said is that it is notoriously difficult to articulate precisely what makes a possibility too remote for it to be properly ignored. We rely on background assumptions all the time in navigating the world. It may be true that if you strike a dry, well-made match, it will light. As with other generics and “for the most part” generalisations, the claim that this would be so in the possible case that the match is struck is not rendered false by the fact that if you remove the oxygen, then it will not light. McDowell's point, I think, is that relevance is context-dependent and that its context-dependency affects notions to which it is conceptually linked like that of critical status, thus understood factively as yielding knowledge. Others have made similar claims (Dretske, 1971; Travis, 2008).

As emphasised in Nancy Cartwright's (2009) work on the general problem of

relevance for evidence-based medicine, the reliance on presuppositions and judgement in determining what options are relevant in the process of diagnosis and treatment choice raises a concern about external validation as not cleanly separable from the language of context and practical capacities. Many other philosophers, regulators and practitioners share this concern about context-dependence and internal justification. (See Mezzich, 2006); Zachar et al, 2014). Acknowledging such interdependence of content and context is a central feature of my own narrative account.

Advocates of particularism maintain that responsible moral thought and judgment does not *require* a suitable supply of moral principles that can serve as a premise for the conclusion in a moral inference, whether explicitly or implicitly and no matter how sensitively done. Instead, moral knowledge is understood as a practical competence of discernment exercised in particular contexts of evaluative appraisal. Epistemic contextualists, moderate particularists and advocates of the notion of defeasible generalisations in ethics (Lance and Little, 2004; 2008) can all agree on the positive claim that discernment of moral meaning – the salience of individual features (e.g., in a consultation about depression), and the form of their overall normative purport – can only be done in context, and hence *a fortiori* that there is no knowing in advance what difference the presence of some ‘purely descriptive’ fact will make, taken as such and in isolation. This was the point about idiographic judgement and the general problem of relevance.

Jonathan Dancy shares with John McDowell a broad commitment in moral epistemology to the philosophical significance of exemplars, and both regard forms of inculcation in socio-linguistic practice as conditions of moral thought and judgement (Dancy, 1993: 50). On this view, which can be traced back to the ancient conception of practical wisdom or *phronesis* (knowledge as virtue), proper upbringing equips us with a form of appreciative understanding of the human world that puts us in a position to discern or ‘disclose’ the normative or evaluative significance or *salience* of the features of

the circumstances in which we find ourselves. Understanding what response is called for or *merited* in a given case, in turn, involves discerning what we may think of as the overall evaluative or normative ‘shape’ of salient features *as so situated* in the particular case at hand in coming to an overall answer to the question of what is the right thing to do (Dancy 2004, p. 150). The heritage of the ancient conception of *phronesis* in the domain of medicine is a certain theme in Braude (2012) who highlights the significance of practical reasoning in relation to pathophysiological theoretical reasoning, and the importance of bridging the two forms of reasoning in current debates between regulators and practitioners in research ethics.

The practically wise person is identified with someone who has an acquired command of an open-ended *range* of the sorts of differences a feature can make in the interactive treatment process; this command is also what enables them to see *new* differences in the future. Contrast this picture of discernment with a picture of clinical judgement as a command of isolated techniques divorced from other epistemic, social and moral competences. While there is perhaps no sense in which ‘the epistemic status of one judgment can be altered by appeal to another’ (Dancy 2004, p. 156) on the latter picture of clinical judgement as proceeding from a set of isolated techniques, the central claim about discernment is that the knowledge brought to the new case is a *practical competence*, not *nothing*.

My interest is in what this tells us about the way in which we can, or should, form our judgements about the case before us. Two models suggest themselves. The first is to say that practical understanding proceeds in two steps; recognition of the salient contributing features and their individual combinations in the first instance, and to work from that recognition to an understanding of what response is overall required here. (A similar argument could be made about the nature of moral perception; for discussion see

[anonymized].) The other model is an integrated *no-priority* narrative view. It maintains that we deploy a holistic set of domain-specific skills, a narrative module that enables us to see practical relevance *in* the contributing features as so situated or organised here; a form of *gestalt* or aspect-seeing.^{viii} The claim here would be that seeing salient non-evaluative properties, organised in the right way, is part and parcel of what it *is* to see (or otherwise represent) salient *gestalts*. Thus, to continue with our earlier example of interpreting particular uses of the general concept *depression* in the idiographic formulation (Section 3), the claim would be that we see, e.g., Cyclothymia (Bipolar III) *in* the way that the subject talks about her depressive symptoms, as opposed to seeing the mood disorder by seeing her symptoms. It is this model as *gestalt-seeing* as a clinical tool for discernment that I support as the one most likely to generate a defensible particularist epistemology in the present context.

To illustrate how the implementation of the positive suggestion about gestalt seeing might look in practice in the way practitioners might think about a diagnosis, a treatment outcome or a patient in novel cases, consider Joseph Parnas's work on clinically grasping the *eidōs* of schizophrenia spectrum disorders, where the unique (rather than essentially private or ineffable) manifestation of the condition in the clinical interview is seen as the most important factor in achieving empathetic understanding and connection with the patient as a person.^{ix} Parnas (2005) tries to operationalise the assessment of subtle self-disturbances (schizophrenia being understood by him as a self-disturbance) in his Examination of Anomalous Self-Experience (EASE) manual. EASE is defined as 'a symptom checklist for semi-structured, phenomenological exploration of *experiential* or *subjective* anomalies that may be considered as disorders of basic or 'minimal' self-awareness.' (Parnas 2005, p. 236). The manual is partly motivated by the intrinsic difficulties of comprehension in schizophrenia spectrum disorders, in a way that I hold points to an important difference between the first- and second-personal perspectives on

experience in patient-clinician communication. Metaphor, intimacy, and what we may think of as pre-scientific sensibility in the use of concepts, are all claimed to be necessities. Rather than thinking of metaphor as a linguistic device for meaning-transfer to convey (or simulate) an underlying ineffable or essentially private experience, Parnas (2005) gives the following characterization of the use of narrative metaphor in the semi-structured interview:

[A]n experience (non- or prelinguistic), especially of the prereflective type, becomes progressively conceptualized, i.e. transformed into a conceptual (linguistic) format, in order to be grasped by the reflecting subject, thematized and rendered communicable to others. The metaphor should be seen here as a basic functional aspect of this symbolization process, where it operates as a linguistic vehicle or medium through which the experience first articulates itself and so becomes reflectively accessible. The metaphor is therefore the first stage of making a prelinguistic or prereflective experience explicitly accessible to oneself and to the other. The choice of metaphor is linked to the nature of experience in a noncontingent way, i.e., *experience and metaphor are not entirely independent*. (Parnas 2005, pp. 237-38),

While a patient's experience might in some way 'dictate' the metaphor the clinician chooses, a patient's first-personal narrative stance on experience need not always meet the second-person narrative stance of the practitioner in relational empathetic attunement. Such convergence may not always be possible due to the intrinsic difficulties of the interview in schizophrenia spectrum disorders, for which reason the use of metaphor and projective understanding may be all the more important in understanding the patient

(without experiencing her mental states for yourself). Instead, it points to the dynamic and interpersonal nature of experience as a form of mutual and open-ended exploration in the search for connection in therapeutic engagement (see [anonymized]).

Another example taken from narrative medicine literature is Rita Charon's (2006) discussion of the case of Luc, a patient who presents with light headaches seeking Charon's signature on a disability form, in a way that annoys the physician to the extent that the physician starts fabricating her own (grossly inaccurate) story of the patient as an aspiring fashion model in financial difficulty. As it turns out, Luc was escaping domestic sexual abuse and trying to set up a safe environment where she could also bring her younger sisters (Charon 2016, p. 6). The moral of the example is meant to show the benefits to clinicians and caregivers of keeping narrative "parallel charts" alongside the regular hospital chart, as part of one's continuous professional development and critical reflection to seek further information that one might otherwise miss.

So far, I have sought to defend and develop the claim that the understanding that the experienced judge has is not restricted to her local circumstances through the use of clinical examples. If I am right, the clinical examples discussed above show that the clinician's understanding is not the epistemic upshot of isolated "individualized" judgements in dealing with novel and difficult or new cases. It is rather the result of situated projective understanding and clinical expertise, in which case atomism about (medical) knowledge does not follow. With this in mind, I now return to my previous suggestion that the emphasis on discernment and narrative understanding as a model for normativity in medicine is helpfully compared with our capacity to talk together. This, I will argue, brings into view a new perspective on shared decision-making distinctive of my novel articulation of particularism as a general procedural model internal to the very *ethos* of good clinical practice.

6. Language and Virtue in Storytelling: Corrective Narrative Empathy Revisited

A narrative like the one we find in prominent stands of narrative medicine (such as the aforementioned use of ‘parallel charts’ in Rita Charon’s work) frames the objects of evaluative appraisal, where the framing is a result of selection, prioritisation, and organisation not only on behalf of the author but also the participating reader. On one narrative, an individual is described as manipulative; but on another, as a survivor of sexual abuse and emotional neglect. Because so many different narratives are often possible, some philosophers naturally worry that the narratives are never *revealing* moral reality but only *constructing* it. It is however a mistake to think that either constructivism or relativism is entailed by the fact of different narratives because these are *conceptions* of the object of inquiry, not the object itself. There is no implication, or so I claim, for the meaning or nature of the object of evaluative appraisal from the fact of different narratives (for further defence of this claim, see [anonymized]).

I argued earlier (Section 3) that the general problem of relevance in understanding the significance of *point of view* in clinical practice is not merely the narrower theoretical problem of formulating general conditions of epistemic relevance. It is also about the practical problem of determining *which* answerable stance the subject expresses in using general concepts (such as ‘depression’ or ‘mental illness’), and how attention to this communicative (verbal and non-verbal) aspect of narrative in the clinical encounter might influence conceptions of diagnosis and treatment decision-making. As noted by Solomon (2015: 181), narrative techniques are partly about recognising *psychological* differences between patients to yield effective treatment and management: the practitioner needs to recognise and accommodate the value commitments and preferences of the patient who presents themselves in the consultancy room. Indeed, such evaluative aspects of health care are particularly pressing in psychiatry and mental health where an underlying

agreement of personal value commitments can be lacking (see Fulford, *passim*). However, as emphasised by Solomon (2015), narrative reasoning is also motivated by other first-personal concerns that are operative in the practitioner-patient *relationship*. I maintain that the dynamics of that interpersonal relationship are part and parcel of what it means to address the patient's needs to be seen *as* a person in humanistic empathetic care – without thereby reducing truth to a perspective.

That the resulting account preserves a critical distance between perspective-taking and value in psychiatric diagnosis and treatment, is, I claim, a key advantage of my account over the aforementioned popular idea of self- or personhood as *identical* with or *constituted* by autobiographical narratives. And the reason is that one can also adopt a second-personal stance on one's own experience and address oneself, where the relationship between the first- and the second-personal narrative perspective *on* experience and self-understanding is itself a dynamic and open-ended evaluative process. Consider a perfectionistic patient for whom self-compassion is a challenge at a basic level due to, for example, formative attachment difficulties. Suppose that the subject gradually comes to disavow their excessively high performance-standards because they no longer self-*identify* with the perfectionistic, but negatively orientated, standards of their old self. On my integrative approach, the relevant sense of 'narrative' is treated as a pre-reflective structural ability or transcendental condition for agential self-awareness as opposed to a constitutive feature of selfhood itself. This, I maintain, also explains self-awareness, the subject's ability to relate to the experience of misery and the agential sense of failure, authentically recalled, is part and parcel of understanding the normative shape of their life as a whole.

To make good this claim we may follow Schechtman (2017) who, in response to Goldie's (2012) criticisms of her initial account of narrative empathetic access to a first-person perspective one previously inhabited as *constitutive* of personal identity and selfhood (see Schechtman, 2001), distinguishes between occupancy and endorsement of past

schemas. Schechtman (2017) in her *precis* of the position on narrative thinking and selfhood, retains the claim that narrative empathetic access over time is necessary for personal identity over time, but adds the crucial modification that the relevant sense of self-narrative reasoning is a phenomenological *structural ability of relating*, in a first-personal way, to all of the perspectives one has occupied as part of a single historical life as a person. Moreover, Schechtman (2017) maintains that mere *occupancy* of past schemas in a first-personal way is not sufficient for having an authoritative or authentic agential sense of self as a person; the subject must also *endorse* the relevant first-person perspective of one's autobiographic historical memory for the concept of narrative empathetic access to be applicable. An interesting feature of the modified proposal is the implied corollary that narrative empathetic access to first-personal stances previously occupied or inhabited in one's life is compatible with a *metaphorical* notion of (non-unitary) 'multiple selves', some of which may have been lost or disavowed (Schechtman, 2017: 20-21); elucidating the relationship of the idea of multiple selves to that of the unity of a person, I invite as an area for future research for personality theorists and philosophers alike.

7. Concluding remarks

The acknowledgement of medicine as a normative practice (as opposed to mere opinion) has led to the idea of shared decision-making as the gold standard for clinical practice, a model that reintroduced the need for clinicians to make value judgements *together* with their patients in the interactive process of treatment established through dialogue. What I have outlined in this paper is a novel realist conception of the moral significance of the first-person perspective in clinical understanding, 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.

By calling into question the sharp dichotomy between ‘art’ and ‘science’ implicit in many recent interventions or critiques from the medical humanities as yielding a potentially misleading and incomplete model of the epistemic situation, the present analysis also proposes to deconstruct a binary set of concepts of health as either “subjective” or “objective”, “evaluative” or “factual”, “particular” or “abstract”. Though I have used the terms “evaluative” and “evidence-based” fairly freely, that has been because the debate about narrative understanding that I have entered has been parsed in those terms. My own view is that the notions of descriptive and evaluative meaning are not really coherent as currently used in the philosophy of science, clinical medicine, and philosophy of psychiatry. Evaluation and description are indeed distinct at the level of the language that figures in narrative idiographic formulations, but that distinctness does nothing to establish a difference in kind between facts and values, descriptive and evaluative properties, classifications or anything much at the ontological level. Nothing that I have said about narrative structure in medical judgement destabilises the notion of truth in medical approaches to diagnosis a natural property. Instead, in arguing that the very concept of ‘relevance’ is itself an occasion-sensitive notion in diagnosis, the analysis points to a wider conception of validation whereby the range of possible answers to the question of what adequate justification of clinical judgement can consist in is not determined and pre-fixed by some particular understanding of the natural sciences. As emphasised by Nancy Cartwright (1999), the concern about external validation is not only a concern for narrative formulations and the medical humanities; *any* discipline where correctness is at issue requires background knowledge, presuppositions and reliance on an acquired sense for what matters and when.

Once we take seriously the suggestion that the medically relevant facts about the particular patient, the object of clinical judgement and diagnosis, cannot be accessed except *through* some perspective, an alternative to the conceptual map with which we started

begins to emerge. 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 the discerning compassionate practitioner. And the reason is that professional medical judgement (and the evaluative outlooks of historical individuals more generally) is no longer theoretically construed as mere *opinion*, a type of “evidence” that is to be weighed against independently specifiable statistical medical facts; rather, professional judgement is ‘the means for adjudicating between alternative sources and weighing their relevance to the individual problem at hand’ (Loughlin et al 2013, p. 141). The resulting options are either to think that a flattened clinical landscape eschewing any distinction between fact and value is no bad thing, or to develop something akin to the kind of narrative particularism I have here begun to sketch.^x

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Reference 2 [anonymized].

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ⁱ The different ways of characterising particularism as a metaphysical claim about the nature of reasons or as a claim about discernment and practical judgement in moral epistemology are of course related. In previous works I have cast the debate over discernment in semantic terms in articulating a robust realist model of thick evaluative concepts (ANONYMIZED), which further informs a realist account of value in self-cultivation in concept application (ANONYMIZED) – an attitude that I have argued is also found in the works of Iris Murdoch and John McDowell (and earlier formulations of particularism in Dancy, 1982, 1983, and 1993).

ⁱⁱ I here set aside the complex question of translational research with practitioners. For excellent discussion of certain key new methods for research and clinical care that have reshaped the practices of medical knowledge over the last forty years, see Solomon, 2015; Braude, 2012; Loughlin, 2014.

ⁱⁱⁱ For example, Savulesco (1995) uses the idea of shared decision-making as a non-coercive form of paternalism such that clinicians start with a of what is best for their patients and then argue with them in reaching an all-things considered value-judgement.

^{iv} Another dimension of the emphasis on patient narratives in clinical practice in the literature is the idea that autobiographical individual patient narratives are important for the topics of selfhood, personal identity, and self-knowledge. On many views within the narrative medicine movement, for instance, selfhood is typically identified with narrativity (see Brody, 2003: 2). While such radical perspectivalism *could* be read into the narrative particularist approach it is by no means mandatory, and certainly not something that I myself endorse.

^v I borrow the term ‘uptake’ from J.L Austin’s (1975) speech act theory. My use of the term in accounting for the significance of narrative understanding and perspective-taking in our capacity to talk together owes much to the analytic origin of a descriptive rather than prescriptive

methodology of ordinary language philosophy but I am not able to defend this claim here. However, while I defend a normative account of medicine, it should be noted that my particularist account is yet “descriptive” in its methodology because, and in as much as, it incorporates anthropological elements from social epistemology and empirical aspects of clinical psychology and psychotherapy research in its endorsement of case studies and patient narratives; see endnote vii below.

^{vi} Jonathan Dancy’s 2004 response to this challenge seeks to undermine the scepticism that drives the original objection. The proposed solution consists in invoking the notion of ‘epistemic filter’, which serves to constrain the possibilities that the agent has to take into consideration. I return to this issue in Section 4.

^{vii} I thank Bill Fulford (private conversation) for this example.

^{viii} I borrow the term ‘narrative module’ from Tim Bayne and Elisabeth Pacherie (2007). My use of the term here does not depend on their argument concerning mental agency as such.

^{ix} I thank Richard Gipps for drawing this material to my attention.

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