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Risky Business: Medicine and Postmodernism

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Introduction

Medicine's need to adapt to the insights of postmodernist theory and the realities of 'postmodern' society is being increasingly asserted. Proponents of a postmodernist medicine urge a view of the world as constituted by multiple realities, focus on particularity and lived experience, and reject our allegiance to allegedly discredited 'metanarratives' like science and truth. We are encouraged to concede the obsolescence of traditional hierarchies and authorities, especially now that the internet has begun to democratise information, and to empower consumers to negotiate the health market place. Information is to be preferred, as both concept and tool, to knowledge, an illegitimately objective concept. Some theorists even suggest that we should recognise value as a crucial component of medical practice, as if this were a revelation of postmodernist thought.

I argue that postmodernism's medical apologists are belatedly endorsing what are essentially modernist influences, and fail to see that a thorough application of postmodern theory to medical practice would be incoherent. Correcting these confusions should alert us to some negative possibilities of medicine's flirtations with postmodernism.

A Core Understanding of Postmodernism

Pre-modern society based belief on intuition and the external authorities of gods, myths and traditions (Chan and Chan, 2000). The beginning of the Renaissance – the rebirth of artistic, scientific and geographic discovery – allows us to identify the familiar periods of antiquity, the middle ages, and modernity (Pippin, 1999, p.19). Philosophical modernism can be conceived as the emergence and consolidation of a number of themes, including

> … a view of nature as to be mastered, not contemplated; a mathematizable and materialistic view of nature; a rejection of final causes in explanation; compared with antiquity, a much more 'realistic' view of the ends to be achieved by knowledge, ends such as health, pleasure, freedom from pain, and not, say, wisdom; an expectation of great social benefits from the free and unimpeded pursuit of scientific knowledge, and a corresponding assumption that the fundamental cause of human injustice was scarcity, that this problem could be corrected; and a general belief in the progressive and politically ever more enlightened course of human history (Pippin, 1999, p.20).

Modernism made man the centre of the universe, and internalised authority to autonomous human reason, which has progressively delivered the achievements of science (Gutting, 1999, p.2). Pinning down postmodernism is not so straightforward, partly because postmodern theory views definitions as slippery and self-deceiving, as committing the sin of essentialism, and is therefore coy about specifying its own nature. Nevertheless, I suggest that at least the following broad themes are discernible, and that a number of postmodernism's current medical interpreters have them in mind when they suggest changes to practice.

According to postmodernism, science itself acts as another external authority, instead of liberating individuals from oppression. In contrast, postmodernism privileges subjectivity, personal narrative, experience and intuition over what the scientific methods of generalisation and inductive inference claim to reveal. Postmodernists reject claims about the objectivity of science (Muir Gray, 1999, p.1550). It is important to distinguish this from the rejection of scientism, 'the belief that science, especially natural science, is much the most valuable part of human learning' (Sorell, 1991, p.1). Many, perhaps most scientists, are happy to reject this latter belief.

Combining these positions produces the relativist stance of postmodern theory. Every good scientist will concede that knowledge claims are contingent in the sense that they might be wrong. Postmodernists attenuate the idea of any underlying 'way things are' to that of historico-cultural situatedness

(Morris, 2000), and many consider that the only possible condition of 'truth' is agreement with others. For example, Richard Rorty claims that the only difference between the natural sciences and those pursuits which many people would not want to distinguish as science (for example literary theory) is the higher degree of consensus amongst the natural scientists (Rorty, 1991, p.40). He makes no inference from the consensus amongst the natural scientists and the predictive success of their disciplines.

The two senses of contingency are thus quite different. Scientific contingency is the acceptance that a claim of fact might be wrong. Postmodern contingency rules out the scientific variety by restricting the conditions of truth to consensus or power or desire.

Having no privileged epistemological status, science becomes one perspective amongst others (McNeill, 1998, pp.102-106), and its content is not something waiting to be discovered, but a construction of human beings, 'always provisional and contingent on context and power' (Hodgkin, 1996, p.1568). Truth, according to postmodernism, is constructed in response to our needs, but also to satisfy the purposes of those in power. Concepts, definitions and whole discourses are constructed. As Alderson says, postmodernists are sceptical about what truth is and what is claimed as knowledge (Alderson, 1998, p.1009).

For the postmodernist, science is a story about the world which has no greater claim to allegiance than any other collective or individual story. Meaning and interpretation are individual, since they relate to lived experience. Individuals have perspectives on the world which are relative to others, rather than being objectively true or false; they are exclusively particular rather than universal; they are constructed and not discovered.

In this paper I understand postmodernism in this more radical sense of particularity, perspectivalism, and relativism, and I will suggest that if postmodernism's medical interpreters are actually defending what amounts to a liberal humanising influence on practice, they should cease regarding themselves as postmodernists.

'Postmodern' Medicine

How are these themes being applied to medicine? Hodgkin has suggested that doctors must now attempt to see things 'perspectivally'. Perspectivalism here is defined in terms of clinical reality, patients' beliefs, community need, and the ethical questions these inevitably raise. Doctors are predicted to become purveyors of choice (often for non-medical ends) rather than traditional disease fighters (Hodgkin, 1996). Individual and public preferences and values are to be factored into decisions on health spending as well as the evidence for the efficacy of the particular project, because what we value should contribute to any opinion on which a decision is based (Muir Gray, 1999). Some senior medical educators have described postmodern medicine as that which incorporates value into its practice (Brooks *et al.*, 2000).

Much greater attention is to be paid to the risks of medical interventions, such as drug therapy and operative procedures, in postmodern practice, in contrast to the positive spin and biased publicity given drugs in recent times (Muir Gray, 1999, p.1551). This is said to be a postmodern response to the blindly optimistic modernist conceit concerning the achievements of science.

Narrative approaches to practice have received significant recent support (Greenhalgh and Hurwitz, 1999), and are said to exemplify postmodern attention to human value, uniqueness and perspective. In the area of narrative based psychotherapy, Holmes has suggested that narrative based medicine and evidence based medicine are not in conflict (Holmes, 2000). Narrative techniques augment patient-doctor communication, aid diagnosis and can have a therapeutic effect (Brody, 1997). Some postmodern practitioners would even 'question whether current science and technology have the ability to give us the evidence vital to the practice of evidence based medicine' due to biases inherent in selection of publishable journal articles and according priority to particular kinds of trials (Chan and Chan, 2000, p.333). Who, after all, they say, determines how the best evidence is derived? Will researchers' values and interests define what qualifies as best evidence? Postmodern doctors, we are told, would also help demonstrate how research is profit-driven, not motivated by a pure search for the truth!

Postmodernism and 'Postmodern' Medicine

Let us consider these assertions.

I understand modernism to be that historico-cultural phenomenon which placed human reason at centre stage in the derivation of epistemic, social and moral authority for human communities, and helped erode many of humankind's

spiritual certainties. Now, accusations of scientific hubris are at times accurate. Science is often viewed as the certain instrument to happiness, progress and wellbeing, yet we continue to crave meaning and a sense of the spiritual. So we are at least justified in rejecting scientism.

However, as we have seen, scientific and postmodern contingency are not the same. Contingent scientific probability is not equivalent to a perspectivalism which one has no reason to rely on. Much medical science and evidence-based medicine (Sackett *et al.*, 1996) produce probabilistic knowledge. It is not necessary to be certain of something in order to be rationally compelled to believe it is true. An achievement of modernism is that the provisional discoveries of science provide us with a more rationally compelling picture of the world than previous accounts.

Consider the claim that intervention risks will receive greater attention by postmodern practitioners. Does not the exposure of risk depend on finding the evidence for which risks apply to particular interventions, and the extent to which they occur? This is hardly postmodern, if we recall that postmodernism is not just against scientism but considers science to be a perspective.

Consider next the adoption of narrative approaches which focus attention on those unique aspects of human experience for which science allegedly cannot allow. Holmes's suggestion that narrative based and evidence based medicine are not in conflict implies that they are distinct but complementary approaches. Yet we would not think that narrative approaches were worth the candle unless there was evidence, at least of some kind, that they were beneficial (Holmes, 2000, p.96). At first the evidence may be simply based on recalled experience, rather than statistical investigation. (Proponents of evidence-based medicine realistically argue that therapy should be advocated on the basis of the best *available* evidence.) The point is that it is a mistake to think of narrative approaches and evidence based approaches as members of the same conceptual category. We could think of narrative approaches and pharmacological approaches in this way – they are both methods of providing relief to people with psychological illnesses. We look for the evidence that *each* approach is effective. We may find evidence that each is more effective in particular situations or conditions, and that in other contexts they are more effective in combination than either approach alone, and we should be compelled by good evidence. Evidence based medicine constitutes a different and more general conceptual category from narrative or pharmacological or any other kind of therapeutic approach. We should therefore not think of narrative approaches as exemplifying a *postmodern* concept of medicine, since that concept eschews the need to satisfy scientific truth claims about the effectiveness of a treatment methodology.

What of publication bias and the prioritising of certain kinds of empirical inquiry? These are legitimate questions, but again they are not postmodern. Questions about publication bias are motivated by evidence of the manipulation of science, just as we might see twentieth century events such as nuclear testing or the Holocaust as instances of science serving questionable or evil human ends. However, postmodernism goes further than describing how science can be misused; it asserts that scientific rationality itself is significantly responsible for twentieth century horrors (Smith, 1998).

In relation to the privileging of certain kinds of scientific inquiries, the postmodern tendency is to infer from the fact that random controlled trials are accorded the highest rank in the hierarchy of evidence quality, that elements vital to a complete medicine will be lost by this ranking. However, if the best evidence for treating a particular condition cannot be derived from a random controlled trial, it does not follow that science is fundamentally deficient. What follows are questions about what kind of investigation is most appropriate to produce compelling evidence about the best approach to the particular clinical problem, and the straightforward inclusion in therapeutic deliberations of the elements which science cannot provide.

Let us finally consider the claim about values in medical practice. Postmodern practitioners are urged to be aware of the multiple perspectives relevant to the consultation, including the patient's beliefs and the community's needs, and they have been predicted to be primarily facilitators of consumer choice. If it is correct to describe the core of modernist thought as the focus on autonomous human reason, then locating individual values and self-determined choice at the heart of the clinical interaction is a straightforwardly modern development. Did not Descartes attempt to base all knowledge on the one thing of which he could be certain – his subjective existence? Did not the great modernist Kant

build his deontological ethics on autonomous human reason? Has not recent western medical ethics, based in part on the ideals of individual freedom and liberty, defended the self-determining human subject / patient against the coercive ways in which medical science and power can be employed as external authorities? Are these individual-focused values not reflected in the deluge of biolaw enacted over recent decades (Van der Burg, 1997)?

A Semantic or Substantive Issue?

The need to *recognise* different viewpoints and value systems does not amount to the perspectival*ism* which lies at the heart of postmodernism. The first idea simply means that different parties often have conflicting needs and values, whose resolution requires negotiation and sometimes compromise. Concerns for justice gain a foothold in such situations. At most, the recognition of incommensurable perspectives leaves the soundness of evidence-based recommendations untouched. Perspectivalism is the much more fundamental philosophical claim that truth itself is perspectival – that there is no method of adjudication between claims to objectivity.

Enough has now been said to suggest that a medicine true to the fundamental themes of postmodern theory would be incoherent. Thoroughgoing relativism, radical scepticism about science, and accepting the inevitability of power's domination are incompatible with medical practice and medicine's goals as we recognise them. Defenders of postmodern medicine might reply that their suggestions distil only postmodernism's good points, that these will humanise and balance an otherwise authoritarian, evidence based, hard nosed practice, and that 'lived experience and science are not mutually exclusive alternatives' (Chan, 2000). It seems to me, however, that in making such accommodations, they have ceased defending postmodernism, and are virtually presenting a case for the familiar values of western bioethics.

Nevertheless, re-emphasising and strengthening the human side of medicine is surely a good thing. What is urged, including attention to patient narrative, honest risk assessment and disclosure, and the better recognition of value and individual perspectives, has already enriched and improved practice. Some theorists have suggested that postmodernism itself is a misnomer, that its deconstructive strategy is really an enlightenment impulse based in reason (Gutting, 1999, p.176), and that what we are currently witnessing is late modernism employing its own considerable resources to adjust itself to new challenges. Perhaps some of postmodernism's medical proponents have therefore erred only in a technical sense, by thinking they are subscribing to the tenets of theoretical postmodernism, when they urge humanising changes to practice. So how likely is it that the mere tendency to follow intellectual fashion will have any significant negative effects? That is a most difficult question to answer, but I offer a caution.

'Postmodern' Medicine – a Dangerous Ideal?

The apparent attractions of postmodernism include its emphases on particularity over generalisation and 'grand theories' (like science), the recognition of individuality and multiple realities and perspectives, and the abolition of unilateral medical authority.

Now it is appropriate to deconstruct discourses and practices which exclude and exploit people. Nevertheless, I suggest that the recognition of the rights, differences and individuality of groups and individuals is only maintained by allegiance to something approaching a fundamental universalism about human nature and value (Eagleton, 1996). If our only stories are those of difference, nothing ties us to common allegiances and obligations, including respect for others' values. If we jettison all our metanarratives, be they scientific or humanistic, we risk losing the ability to critically interact, since no one's perspective commands greater epistemic authority than another's in a world of pure particularity. Yet the question about which particularism we ought to choose always remains open (Callahan, 2000). The world of pure particularity is incoherent, because not only do even we individualistic westerners continue to form ourselves into and identify as groups, we would not survive if we did not continually generalise, abstract and theorise about ourselves and the world. Part of the art of medicine lies in identifying patterns which arise from the patient's individual narrative, out of which doctor and patient can together develop a response. That patients assign particular meanings to their experiences does not prevent doctors from helping them, in the light of their knowledge of how others have made sense of *their* experiences. The risk of dallying with perspectivalism is to become less responsive to patterns, and hence less able to entertain the possibility that patients, because they are human, sometimes mistake or distort facts, sometimes make incorrect inferences, and sometimes favour certain perspectives for

corrigible reasons. The risk of being excessively influenced by postmodern theory may be to lose the ability to respond to shared needs rather than occurrent individual desires.

This is not to say that need is defined and fixed by esoteric medical knowledge. The idea of a negotiated strategy bringing together the patient's goals and values and scientifically authoritative information regarding available options, actually offers greater respect and recognition to the patient as a distinct 'other', than an approach based on postmodern incommensurability, which denies or severely limits the ability of both patient and doctor to grow and change. Dialogue and negotiation achieve variable levels of understanding and agreement through rational interchange (Savulescu, 1997). Accepting that the world is just a conglomerate of multiple realities reduces dialogue and negotiation to chatter or, at best, transaction.

Although its medical interpreters may in fact be urging a better balance between a dominating biomedical model and the human aspects of medical care, further uncritical appropriation of postmodern theory might therefore help to push medicine in the direction of an effete service industry, which would be to have capitulated to the very worst tendencies of late modernism. The central task for medicine, no less than for modern society in general, is simultaneously to accord science a primary place in the development of knowledge, and to avoid trivialising the normative core of human experience (Gutting, 1999, pp.173-6).

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