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In Defence of Professional Judgement
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Robin Downie and Jane Macnaughton

Robin Downie FRSE, FRSA, Emeritus Professor of Moral Philosophy,
University of Glasgow, Glasgow G12 8QQ.

Jane Macnaughton MA, MB ChB, MRCP, PhD, Director, Centre for
Arts and Humanities in Health and Medicine, Clinical Senior Lecturer,
University of Durham, Durham DH1 3LE

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Abstract

A judgement is an assertion made with evidence or good reason in a context of uncertainty. In psychiatry the uncertainty is inherent in the professional context, and the evidence derives from the academic literature and scientific studies as they are applied to a specific patient. The nature of the uncertainty and the factors which should inform professional judgement are explored. Professional judgement is currently facing two serious challenges: an obsession with numbers, which comes from within medicine, and the ‘patient choice’ agenda, which is politically inspired and comes from outside medicine. This paper strives to defend professional judgement in the clinic against both challenges.

The nature of judgement

A *judgement* is an assertion made with some evidence or for a good reason, in a context of uncertainty (Reid 1785). There can of course be bad judgements when the evidence is defective. For simplicity we shall use the term ‘judgement’ to refer to good judgement. There are two basic types of (good) judgement: theoretical and practical. A theoretical judgement is an assertion about what is probably true or correct, and a

practical judgment concerns what we ought to do. In both cases there must be some evidence or some reasonable considerations determining our judgement; otherwise it is not a judgement but a guess. And in both cases the context must be one of uncertainty. We do not *judge* that $2+2=4$ because we *know* it with certainty. Theoretical and practical judgements are of course often linked in that our judgement of what we have good evidence for believing can be grounds for our judgement of what we ought to do.

A *professional* judgement is a judgement made in a professional context. It can be either theoretical or practical. More explicitly, the uncertainty derives from the professional context, and the evidence or relevant considerations are acquired by means of professional knowledge and skills. We shall first explore the professional context which gives rise to the uncertainty, and then suggest the factors which should inform professional judgement. It will emerge from this analysis why professional judgement is worth defending against some current threats to it.

Factors which create uncertainty in the professional context

Firstly, there can be uncertainty concerning the diagnosis. This is notoriously the case with mental illness. Secondly, even when the diagnosis is reasonably clear there can be uncertainty about how long the illness will last and whether it will give rise to any connected complications. Thirdly, there can be uncertainty about the treatment. The evidence suggests that it will lead to an improvement in 65% of cases, but will it be of benefit for *this* patient? Fourthly, the patient may be uncertain. Patients are by the very nature of their situation in a weak position, and the patients of a psychiatrist are among the most vulnerable of all. They may be confused, hostile to the psychiatrist, and resistant to all treatment, or reserved and uncommunicative. Uncertainty about how to proceed is inevitable. These four types of uncertainty (there may be others) can be summed up by saying that in all medical situations there is likely to be a varying degree of uncertainty about what is in the patient's best interests, and that this uncertainty is at its maximum in psychiatric cases. The first condition for professional judgement - uncertainty - is therefore manifestly present in psychiatric cases.

Factors which should determine professional judgement in psychiatry

Theoretical factors. The first theoretical factor is obviously the long training in medical school and thereafter the specialised training required by the Royal Colleges and other institutional bodies concerned with the making of the competent consultant. But despite the emphasis on the academic side of medical training it remains importantly a kind of apprenticeship based on the model of ‘see one, do one, teach one’. Bedside teaching remains of the first importance for informing the judgement of the trainee psychiatrist. This may be especially true for the art of diagnosis.

Secondly, the judgement of the psychiatrist should be informed by the evidence which derives from trials. ‘Evidence-based medicine’ (EBM) has for many years been a widely accepted slogan and all branches of medicine insist on continuing medical education (CME) where the latest evidence-based treatments are discussed. There can be no doubt that technical knowledge deriving from EBM must be dominant among the factors which determine theoretical judgements in psychiatry.

Practical factors. Practical judgements will have EBM as a central component. But EBM is by no means the only relevant factor which should determine practical judgement. Doctors must also know when, how, and how much to exercise their skills. For example, what is the balance of benefits to harms and risks? Does the patient really understand these? Has the patient consented to the risks? What are the long-term prospects of recovery? This kind of judgement is of a different order from diagnostic and treatment judgements; it certainly involves technical judgements, but it also involves judgements of (broadly speaking) moral value. Judgements of this kind are unique to medicine and in order to understand their importance we need to consider the special relationship which the psychiatrist has with a patient. It is in this special relationship that we shall find the third and fourth factors which should inform the professional judgement in psychiatry.

Relationships: bonds. The word ‘relationship’ can be used in two ways (Downie and Macnaughton 2000; pp 78-89). It can refer to the bonds which hold two people together, or it can refer to their attitudes to each other. For example, if we see two people together, we might ask what is the relationship between them, and receive answers such as: father and son, colleagues, husband and wife, teacher and pupil, doctor and patient, and so on. To characterise a relationship in this way is to ask about what we are calling the ‘bonds.’ But we might ask what kind of relationship do Bloggs and his son have, and be told ‘Bloggs has great affection for

his son, but his son has nothing but contempt for his father.’ Or we might say of a husband and wife that their relationship is deteriorating, or of that between a doctor and a patient that the patient trusts the doctor and the doctor respects the patient. Answers of that kind characterise a relationship in terms of attitudes. A professional relationship requires both bond and attitude.

The bonds in a professional relationship are decided by the governing body, for example, by the General Medical Council. It is necessary that there should be special bonds between professional and patient because of the inequality in the relationship. In brief, the client or patient is vulnerable and needs the protection of the bond. In general, we might say that the bond takes the form of a role-relationship in which both professional and client have rights and duties laid down by the governing body. For example, a doctor might need to know various intimate details about the patient in order to be able to offer the service. The client must be reassured that no untoward use will be made of this information. Hence, the duties of confidentiality are imposed on the professional. Doctors are told that ‘the patient is a person,’ and so on. Yes, but they are persons in a role relationship when they are dealing with a professional. And the nature of the role is laid down by the professional body, and obviously reflects the values of the profession. In other words, ethics enters a profession via the professional bond.

The third factor which should inform professional judgement in psychiatry is therefore knowledge of the legal and ethical regulations which exist in legislation and in the guidance of the Royal Colleges, the BMA and the GMC. The obtaining of informed consent for treatment is especially problematic in psychiatry where questions of the patient’s competence to consent may be doubtful, and in England the recent Mental Capacity Act has altered the situation. Hence, knowledge of current regulations is an important determinant of professional judgement.

Relationships: attitudes. The professional attitude must reflect awareness of the vulnerability of the client or patient. Often the professional attitude is described by a phrase such as ‘concern for best interests’. It is the doctor’s duty to supply information to the patient and the patient’s right to give or withhold consent to the proposed treatment in the light of that information. Whatever the details of the appropriate attitudes involved in the professional relationship – and we shall have more to say on this - an attitudinal component is the fourth factor which

should inform professional judgement. Indeed, in psychiatry the attitude of the psychiatrist to the patient may be integral to the healing process.

Developing professional judgement

How can the four factors we have mentioned as necessary for informing judgement in psychiatry be developed. There is little difficulty about the factors 1-2. As was said, diagnostic skills can be acquired in various ways but apprenticeship may be the most important way. Information on appropriate treatments can be obtained from the copious literature and data bases. Ethics also can be presented in a learnable and teachable way. Sometimes it is said that ethics is entirely a matter of opinion. As far as medicine goes this view is false. The GMC, BMA, the Royal Colleges and similar institutions in other countries issue guidelines on ethical issues and these represent current ethical thinking. Doctors can and ought to be familiar with these quasi legal documents if they are to make informed and acceptable treatment judgements.

It is much harder to develop what we have called the attitudinal factor in judgement. We might suggest that whereas factors 1-3 of the determinants of good judgement require expert *training*, the attitudinal component requires a broad *education*. What are the differences between being trained to have skills, and being educated in humane values? This, of course, is a large topic in its own right but a few points can helpfully be made here (Downie and Macnaughton 2007; pp. 117-120).

Firstly, the person educated in humane values has a broad cognitive perspective and is able to see the significance of medicine in a total way of life. Secondly, the person of humane education has continual curiosity about the world, a desire to develop knowledge and skills throughout a working life, and connectedly is aware of the standards of work which must be satisfied. Here we have the familiar idea of a 'professional job,' or 'a job well done.' Thirdly, the idea of a humane education embodies the idea of ethics. It is possible to be *trained* to pick pockets, as in Dickens' *Oliver Twist*, but a humane education is necessarily directed to worthwhile ends. Here we have the idea of standards of behaviour, of 'being professional' in one's approach to a client or patient. Fourthly, the broadly educated person has a flexibility of mind which enables her/him to see things in a variety of ways. To paraphrase the words of the educational philosopher RS Peters (1967) to be trained is to have arrived, but to be educated is to travel with a different view. Good judgement requires the constant review of false finalities.

We shall not take up the question of how far undergraduate medical schools or postgraduate CME stress or concern themselves at all with the matter of broad education in humane values. Professionalism has for some time in the USA been linked to the growing field of ‘medical humanities’ and this link is now becoming apparent in the UK (Meakin, 2007). This connection offers the opportunity to broaden medical training into medical education and thereby develop the insights of professional judgement.

On the other hand, there are various contemporary challenges to professional judgement. We shall discuss two: that the need for professional judgement is minimised by stressing the alleged ‘objectivity’ of quantitative data; or by prioritising patient choice over professional judgement.

The distorting effect of numbers: implications for professional judgement

Research in psychiatry is of various kinds, but we shall confine our discussion to qualitative research (Jones 1995). Qualitative research is concerned with such matters as what a disease or a treatment ‘means’ to a patient, or with ‘patient-centredness’ or ‘doctor satisfaction’. Issues of this kind are important since they provide knowledge on which clinical judgement can be based. But if knowledge or evidence is to be useful for informing clinical judgement as it applies to a variety of individual cases it must in some way be generalisable. How can what is essentially qualitative be generalised?

In quantitative research generalized knowledge is acquired via inductive procedures. For example a cohort of patients with a given disorder and other similarities may be selected for a new treatment, and others for a placebo or an existing treatment. The new treatment may be shown to have some success with 70% of patients in the cohort. This generalized evidence is then available to inform the clinician’s judgement in an individual case. The use of numbers and the procedures of randomization suggest that the evidence is ‘objective’, and can therefore be relied on as a basis for judgement in an individual case.

In view of the need to generalise and so acquire objectivity there has been a tendency to force qualitative research into a similar quantitative mould. For example, we find qualities like ‘patient-centredness’ being given a score of 1.45 and doctor satisfaction measured as 8.95 (Law and Britten 1995). We have discussed in detail elsewhere the wider issue of whether

qualitative research can meaningfully use measurements and scales in the manner of quantitative research and will not repeat the arguments here (Downie and Macnaughton 2000; pp. 26-38). We shall argue here that the attempt to generalize and achieve 'objectivity' via numbers actually distorts the way doctors view their patients and therefore distorts their clinical judgements. Finally we shall suggest another way of interpreting qualitative research which has a different kind of connection with judgement.

The single most important factor which leads to the distortion of qualitative research and therefore the judgements based on it we can call 'reductionism'. The term 'reductionism' is used in a variety of ways (Honderich (ed.) 2005) but we mean here the process of seeing human beings and their interactions in terms of a number of discrete features. Reductionism is essential for countability because there must be an answer to the question: what are you counting? In qualitative research those features are (for example) eye contacts, or answers to questions in the form of ticks in a box. But to try to understand patients in this way, in terms of a finite number of discrete features, is to abstract from the complexity and totality of a human interaction. Blood pressure can helpfully be abstracted in this way and measured, but not a human response in its complex totality. There is something not only patronising but clinically misleading in the suggestion that the complexity of human relationships can be reduced to a few factors and 'measured' with an 'assessment tool'.

The desire to use numbers (because they are thought to be 'objective') has a distorting effect in two ways. Firstly, the use of numbers suggests that the knowledge obtained by the qualitative research is a kind of induction-based knowledge when (as we shall see) it is quite different in nature and has a different sort of bearing on individual judgement. Secondly, the application of that knowledge to particular cases has replaced what should be individualised judgement with the mass use of questionnaires, or 'assessment tools'. Medical training rightly stresses the importance of listening skills. On the other hand, the reality is that rather than listen to what the patient may be saying the doctor or nurse presents the patient with a form to fill up and boxes to tick (Randall and Downie 2006). This is done on the grounds that such a procedure utilises countable results which are therefore more 'objective' than simply having a discussion with the patient. It certainly attempts to minimise clinical judgement.

It should also be noted that if the underlying purpose of questionnaires and measurement scales is to avoid the need for judgement then it does not succeed. Judgement is required in deciding what questions to ask, what numbers to assign to them and how to interpret the final scores. Judgements can be dangerous when the professionals are unaware they are making them and believe themselves to be 'objective'.

Generalizability and qualitative research: a different route to judgement

If the knowledge obtained by qualitative research is to be useful in informing professional judgement how should it be viewed? The answer is that the lessons of qualitative research for clinicians are derived from considering the plausibility of the particular situation in terms of their own experience, and on finding parallels which are helpful. The question for the reader of qualitative research is: 'Are there any general features in this situation that I recognize and can apply?' The understanding involved in qualitative research is more akin to the understanding gained from literature and art than that gained from a numerical science. This does not mean that it is an inferior kind of understanding, but it does mean that it is different in that it is reached by a different route and informs judgement in a different way. It requires the active participation of the reader to identify with the situation and relate the findings to his/her own situation. In reaching this understanding the life experience and maturity of the clinician are all-important.

Consider the following example. Sartre (1943) describes a man bending down to listen at a keyhole. He believes his wife is in the room with her lover. Suddenly he hears a step behind him, and immediately his attitude changes. To begin with, he wanted to hear a conversation, but now he has become an object to someone else – an eavesdropper to be described and despised. This example shows how moral emotions, such as shame, are experienced in a social context. The eavesdropper minds being caught because he must now think of himself as mean and sneaky. He despises such characteristics in others and now he must despise himself.

We have used this example because it is similar to many in qualitative medical research. The route to understanding is through our identification with the situation. Through that identification we reach general features of human emotions. There is an element of generalisation, but not by induction. The imposition of quantitative language would obstruct this understanding by distorting the findings of qualitative research and making them obscure to the reader. Even if the

approach of such research is narrative and descriptive of particular situations, for the mature clinician it can still provide understanding of general features of clinical situations which can inform judgement in individual cases.

Qualitative researchers take pride in the fact that their approach provides new insight into clinical situations. They should not hide these insights under a numerical bushel but illuminate it with language that reflects the new kind of understanding they wish to convey. To attempt to put numbers to the research is to distort both it and the relationship between doctor and patient which it is attempting to illuminate. Qualitative research is best interpreted on the analogy of the humanities. Through identification with the particular situation the researcher or clinician can recognise the general elements in human emotion. This is unlike the generalisability of inductive science. It requires a moral maturity from the doctor, and it can lead to a humane understanding of the patient which will produce a humane judgement.

It might be objected that our arguments assume a universality in human emotions which may not exist, especially in psychiatric cases. But even if there is no universality in human emotions and reactions there is a broad similarity, and that may be all that is needed as a basis for individualised judgement. After all, even in genuine quantitative research a success rate of 70% might be thought significant.

Patient choice

‘Patient choice’ is a Trojan Horse in the sense that it suggests the desirable involvement of the patient in treatment decisions. And of course ‘patient choice’ emphasises the right of the patient to *refuse* treatments, for whatever reason (BMA 1998). The problem is however that ‘patient choice’ has now come to mean *consumer* choice, something very different from the choice or refusal of treatments offered by the doctor (Bate and Robert 2005). Consumers’ judgements and choices of the products they want trump those of the sales assistant. If patients are consumers should their judgements and choices trump those of the professional?

What are the conditions of consumer choice? We have discussed the general conditions for consumerism and its threat to the NHS elsewhere and will not repeat the arguments here (Downie and Randall 2008). The threat specifically to professional judgement comes from two conditions

of the free market: that the consumer can determine the options available for choice, and that the consumer must take responsibility for what is chosen. For example, if the shop does not have the goods desired then the consumer is able to turn to the riches of the internet, and bears responsibility for goods so chosen. Let us examine the impact of these conditions on professional judgement.

Firstly, in the traditional model the doctor offers only those options judged to provide net benefit and the patient consents to or refuses what the doctor offers. In contrast, in the consumer model the patient is requiring the doctor to provide what the patient judges to be effective and the patient is then not consenting to the treatment but authorising the doctor to carry it out. The doctor has become merely the agent of the patient. It might be argued that the doctor could conscientiously object to carrying out a treatment the patient requested when the doctor judged that it was inappropriate. But note the extraordinary paradox: in this situation the *doctor* has become the one who consents or refuses and the patient the one who makes the judgement! In short, professional judgement is bypassed.

The second condition of consumer choice concerns the locus of responsibility. In the consumer choice model the consumer takes full responsibility for the choice. In contrast, in the traditional model of choice and consent, the doctor took responsibility for judging which options should be offered to the patient, whilst the patient took responsibility for consenting to or refusing what was offered. The traditional model of choice could justifiably be described as joint responsibility, since each party has responsibility for different aspects of the decision. By contrast, if consumer choice were accepted in the NHS then, logically, the responsibility must pass entirely to the patient, and the need for professional judgement would be much diminished.

Professional judgement and consumerism: some implications

. What would a true consumerist health care system be like? It would have at least two implications of major importance for the whole concept of medicine as a profession, and therefore for professional judgement.

Firstly, the concept of a profession would alter. A doctor or nurse would become simply a purveyor of goods and services, like a plumber or a garage mechanic, or a shop assistant. A doctor would not be required to have the values of the profession, or to exercise professional judgement. For example, the Royal College of Physicians' document on professionalism expects doctors to have the qualities of compassion, integrity, altruism, etc. (RCP 2005). But these qualities do not feature in the consumer choice model and indeed they are out of place in that model. Consumerism has its own ethics and responsibilities, but they are quite different from those of professionalism.

Secondly, consumer choice in the NHS would lead to a change in motivation amongst the professionals. In the consumer choice model the provider of the service is motivated less by a desire to improve the overall welfare of the consumer than to provide goods and services which will satisfy the consumer's requirements at the lowest possible cost to the provider, thus achieving a financially acceptable profit margin. Indeed, the situation is worse than that. Trust is the foundation of the doctor-patient relationship and patients still believe that their psychiatrist is uniquely concerned with their health. There is a reasonable fear that consumerism in the NHS will weaken the unique trust that patients must be able to place in their doctors, destroy the idea of professional judgement, and indeed destroy the whole idea of medicine as a profession.

References

- Bate, P. & Robert, G. (2005) Choice. *British Medical Journal*, **331**, 1488-1489.
- British Medical Association (1998) *Medical Ethics Today*, pp.1-33.
British Medical Journal Publishing Group.
- Downie, R. & Macnaughton, J. (2000) *Clinical Judgement: Evidence in Practice*. Oxford University Press.
- Downie, R. & Macnaughton, J. (2007) *Bioethics and the Humanities: Attitudes and Perceptions*. Routledge-Cavendish.
- Downie, R. & Randall, F. (2008) Choice and responsibility in the NHS, *Clinical Medicine* **8:2**, 182-185.
- Honderich, T. (ed.) (2005) *The Oxford Companion to Philosophy*, pp.793-794. Oxford University Press.

- Jones, R. (1995) Why do qualitative research? *British Medical Journal*, **45**, 131-132.
- Law, S. & Britten, N. (1995) Factors that affect the patient-centredness of a consultation. *British Journal of General Practice*, **45**, 520-524.
- Meakin, R. (2007) Teaching medical students professionalism: what role for the medical humanities? *Journal of Medical Ethics: Medical Humanities*, 33, 105.
- Peters, R. (1967) *The Concept of Education*, p.8. Routledge & Kegan Paul.
- Randall, F. & Downie, R. (2006) *The Philosophy of Palliative Care: Critique and Reconstruction*, pp.35-44. Oxford University Press.
- Reid, T. (1785) *Essays on the Intellectual Powers of Man, Essay Six, Of Judgment*. Lehrer, K. & Beanblossom, R. (eds.) The Bobbs-Merrill Co. Inc.
- Royal College of Physicians (2005) *Doctors in Society: The Medical Profession in a Changing World*. Report of a Working Party. Royal College of Physicians.
- Sartre, J.-P.(1943) *Being and Nothingness*. Barnes, H. (trans.) pp.259-263, Methuen.

Multiple Choice Questions

A Judgement

- A. May be theoretical or practical -T
- B. is made in conditions of certainty - F
- C. is unnecessary in a professional context –F
- D. is undermined by the evidence base - F
- E. is no longer of importance as a result of the patient choice agenda - F

Relationships in psychiatry

- A. Consist entirely of formal bonds - F

- B. consist entirely of emotional attitudes – F
- C. are determined entirely by the patient – F
- D. are independent of ethics – F
- E. influence professional judgement - T

Attitudes

- A. Are determined solely by professional regulation -F
- B. do not affect professional judgement -F
- C. are solely a matter for professional training –F
- D. require an ethical component –T
- E. are irrelevant to the healing process – F

Qualitative Research

- A. requires ‘reductionism’ –F
- B. requires the use of numbers – F
- C. is made ‘objective’ by the use of numbers – F
- D. cannot be generalised – F
- E. can develop professional judgement –T

Patient Choice

- A. has no place in the NHS -F
- B. has now replaced professional judgement –F
- C. involves joint decision making –T
- D. transfers treatment responsibility to the patient –F
- E. does not affect professional motivation -F

Biographical Notes

Professor Robin Downie is Emeritus Professor of Moral Philosophy at Glasgow University. He has interests in the philosophy of medicine, medical ethics and using the humanities in medical education. His most recent book (with Dr Jane Macnaughton) is *Bioethics and the Humanities: Attitudes and Perceptions*.

Dr Jane Macnaughton is Director of the Centre for Arts and Humanities in Health and Medicine (CAHHM) at Durham University. Her research interests include medical humanities, professionalism in undergraduate medical education and arts in health. She has published two books with Robin Downie including *Clinical Judgement : Evidence in Practice* (OUP, 2000) and *Bioethics and the Humanities* (Routledge-Cavendish 2007).

