THOMAS A. LONG

NARRATIVE UNITY AND CLINICAL JUDGMENT

ABSTRACT. Alasdair Maclntyre's recent thinking both about the concept of a practice and the existence of narrative unity in human life raises important questions about how we should view clinical medicine today. Is it possible for clinical medicine to pursue patient well-being in a society (allegedly) afflicted with what he calls 'modernity'? Here it is argued that MacIntyre's pessimistic view of the individual in contemporary society makes his call for patient autonomy in the clinical setting pointless. Finally, recent work in gerontology is cited to make three points: first, MacIntyre's pessimism about us is too extreme; second, the concept of a 'fictionalized' personal history is closer to reality than either MacIntyre's notion of narrative unity or the ideas of his imagined opponent (Sartre); and finally, we should not expect clinical medicine to produce patient well-being, when this is understood narratively.

Key words: Practice, Narrative unity, Patient well-being, 'Fictionalized' history.

I. INTRODUCTION: PRACTICES AND CLINICAL MEDICINE

In his fascinating and controversial book After Virtue, Alasdair MacIntyre defines a 'practice' as follows: a complex, "coopertive human activity" having standards of excellence in the pursuit of which 'goods internal' to it are realized and "human powers to achieve excellence . . . are systematically extended" (MacIntyre, 1981, p. 175). In his explanation of practices, he refers to several and discusses two at some length, but nowhere does he mention clinical medicine as a practice. The reader may attribute this to a quirk in his writing, for if architecture is said to be a practice (as it is), then surely clinical medicine must be one as well.

However, an examination of After Virtue, as well as some of his other writings, shows that for MacIntyre clinical medicine either cannot be a practice, or if it is one, then it is little more than a game.

Practices have 'goods' which are 'internal' to them, and MacIntyre explains the notion of 'goods internal to a practice' through the use of two examples — chess and portrait painting. The goods internal to chess are "the achievement of a certain highly particular kind of analytical skill, strategic imagination and competitive intensity" (MacIntyre, 1981, pp. 175–176). One might speak here of 'the joy of chess', for there is no necessary connection between experiencing these intrinsically good things and the 'external goods' of prestige, status, and money. Indeed, the internal goods of chess have no necessary connection even with winning; the satisfaction lies in coming to play the game well and learning to play it better.

Certainly clinical medicine is a practice at least in the sense in which
chess is so. The internal goods of clinical medicine consist in the achievement of a particular kind of analytical skill (diagnosis, surgical technique), strategic imagination (where to make the incision, when to give the chemotherapy), and competitive intensity (trying different therapies, innovative surgical procedures). Clinical medicine, too, has obvious external goods, typically greater than those of chess, and like chess, medicine’s internal goods have no necessary connection with success in treatment. The practice of medicine often brings wealth and status (external goods), while the mastery of a complex neurosurgical technique (internal good) is no guarantee that the patient will not succumb to post-operative infection. In short, clinical medicine can be viewed, and its practice experienced, as one kind of game.

But MacIntyre speaks of ‘two different kinds’ of internal good. What makes portrait painting different from chess is that the former may issue in an excellent object, and the excellence of this object is a good internal to the practice (MacIntyre, 1981, p. 177). This internal good, though a product of the activity of painting, is quite different from it. So portrait painting is a practice the goal of which is to produce excellent portraits — objects which may continue to exist even if the practice itself disappears.

Now is clinical medicine a practice in the sense in which portrait painting is a practice? Does clinical medicine have a goal analogous to portrait painting? Here let us make an assumption that certainly seems to be in the spirit of MacIntyre’s approach to medical treatment, namely, that clinical medicine seeks to produce or maintain patient well-being.

Of course, well-being is not a spatio-temporal object, but, like a painting, it is independent of the activity which might produce or maintain it. Furthermore, it is at least theoretically possible (however unlikely) that human well-being would survive the disappearance of clinical medicine. But this speculative point aside, how is well-being to be understood?

II. WELL-BEING

Well-being is perspectival in the sense that any attempt to seek or enhance it must reckon with a cluster of beliefs, meanings and values which may (and often do) vary greatly from person to person. Thus, properly seeking a patient’s well-being may not involve any attempt to cure or even ameliorate a disease or medical condition. Someone’s well-being may be seriously affected, unaffected, or even enhanced by the presence of a disease or condition. For example, the treatable condition sterility can be the source of deep depression in someone whose ethnic background