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CLINICAL HERMENEUTICS: FAILURE OF AN APPROACH TO CLINICAL PRACTICE

1. INTRODUCTION

After a brief outline of several theoretical problems concerning medical decision-making, I will criticize hermeneutics as analysed by Stephen L. Daniel. I will study three main points and will demonstrate some weaknesses common to all so-called ‘hermeneutic’ approaches to the theoretical reconstruction of medical practice. In the last section, I will sketch the technique of empathy detached from hermeneutic mystification as an instrument of critical intention analysis. I do not present final results, but rather expose particular problems and indicate approaches to further research.

2. CLINICAL PRACTICE AND MEDICAL DECISION-MAKING

From its very beginning the patient/physician relationship is action-orientated since the doctor is faced with successive questions of the type: ‘Relative to the information given at this instant of time, which action should be performed in order to achieve an optimal result for the patient?’. Thus, he is compelled to select out of the set of all possible actions the most suitable one. Regarded in this way we should reconstruct clinical practice as a chain of actions. Each of the elementary actions, whether a diagnostic or a therapeutic one, is performed on the basis of a clinical decision. The sum total of the deliberations leading to such a decision is designated as the multi-step sequential process of “clinical decision-making”. Each elementary decision is the outcome of a complex situation, characterized by a multitude of factors, e.g., (1) goal of all the medical efforts, (2) diagnostic or therapeutic value of the actions, (3) risks of complication associated with their performance, (4) costs of actions, (5) patient’s preferences and feelings towards the actions, (6) legal and moral aspects, etc. In order to find an effective solution for decision problems in the clinical setting, a more analytic and quantitative approach is attempted by applying mathematical decision theory. The central problem of this approach is the specification of rational criteria for selecting actions as indicated above. However, the use of decision theory for medical practice is substantially restricted by the lack of a clinical action theory that would
provide a clarification of questions like "the value-ladenness of medical concepts, the nature of medical acts and relations, and the justification of norms, goals and decisions in medicine". Accordingly, this desideratum could settle the controversy over the problem of obtaining clinically relevant information through understanding the patient, more precisely, the problem of inferring knowledge from the patient’s verbal and non-verbal expressions. By means of a comprehensive medical action theory not yet available we would be able to discuss this question as a special theoretical problem of medical decision-making.

3. CLINICAL HERMENEUTICS

In his paper, Stephen L. Daniel claims to provide through clinical hermeneutics a "heuristic model of clinical decision-making" (p. 195) that is "perhaps the clearest heuristic model for understanding patients" (p. 205). In my comment, I will criticize his approach and will conclude with an evaluation.

3.1. Semantic Vagueness of Basic Terms

A "four-level method of interpretation" is proposed as a useful tool of knowledge acquisition in the clinical setting. Intended objects of these interpretations are "texts", defined as "any group of signs which constitutes a whole and which takes on meaning through interpretation" (p. 195). Disparate entities like "patient", "patient history" (p. 202), "vital signs", "lab values" (p. 204) are designated as 'texts'. Whereas any given object may be in one way or another regarded as a group of signs, the constitutive property of 'wholeness' is anything but clear. Perhaps the author refers to the metaphoric dictum according to which understanding of a whole is solely attainable through the parts and the parts can only be understood from the whole. In this vague sense healing means the restoration of a wholeness by directing the patient "toward a holistic sense of the truth" (p. 202) about himself. Using 'whole' and 'holistic' in this way, these terms acquire the character of magic words void of any precise meaning. These phrases together with almost all the other basic terms of clinical hermeneutics (like ‘hermeneutic circle’, ‘pre-understanding’, etc.) are really nothing but metaphors. Unfortunately, due to metaphoric ambiguity, a ‘definition’ of a metaphor through a metaphor is absurd. Such an attempt results either in a petitio principii or when used as a metaphor, it becomes