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In 2016, the LabOnt Research Group and the University of Turin organised a workshop entitled *Philosophy and Medicine*, which gathered together philosophers of medicine, language, and cognitive science. The central aim of the workshop was to articulate the relationship between philosophy, ethics, and clinical practices. In the same year, the Italian journal *Medicina e Storia* published a selection of the papers presented at the workshop, which covers a variety of topics ranging from theoretical issues in psychiatry to ethical and linguistic problems in health communication. The message arising from the issue is that no single aspect relating to the theoretical exploration of medicine can be understood in isolation from the others. For instance, no ontological problem can be appreciated irrespectively of scientific methodologies and conceptualisations. Likewise, no ethical question can abstract away from some sort of ontological discussion on what health and disease are. For this reason, each contribution of the issue touches many intertwined questions.

Since I cannot exhaustively discuss all of them in this review, I focus here on two major topics discussed throughout the issue: first, how philosophical perspectives on language and ethics can advise medical practices; second, how philosophical perspectives on health and disease can inform contemporary psychiatric nosology.

The first topic I shall consider is how medical practices and health communication can benefit from a dialogue with philosophy of language, epistemology, and ethics. Although these theoretical branches may seem to be somehow distinct from each other, they turn out to be rather interconnected in medical practice. As Francesca Ervas, Marcello Montibeller, Maria Grazia Rossi and Pietro Maria Salis show in their paper *Expertise and Metaphors in Health Communication* (ivi, pp. 91-108), the diagnostic process generally involves complex inferential procedure aimed at comparing a patient's symptoms and anamnesis with the doctor's medical knowledge. On this view, doctors must be able to disclose the aetiological factors of a given pathology,

identify its potential treatment, and frame the patient's experience into a clinically-significant picture. In this tortuous process, health professionals need remarkable efforts to *effectively* communicate with patients about their condition as well as to suggest prevention and therapeutic strategies: that is, they have «to transfer to the patient a set of information that justifies, on a rational basis, decisions that will impact patients' everyday life» (ivi, p. 98). On the other hand, as Vera Tripodi argues in her paper *Epistemic Injustice and Medical Diagnosis* (ivi, pp. 147-157), diagnosis usually relies on the patients' ability to describe their symptoms as precisely as possible – after all, patients are the very experts on their feeling. This two-way transfer of knowledge makes clinical practices incredibly delicate.

Ervas and colleagues analyse shortcomings in communication from health professionals to patients and point at metaphors as invaluable epistemic devices to grasp a given technical, otherwise obscure concept (e.g., the characterisation of a disease as well as its aetiological factors) by means of another, more familiar one. More precisely, metaphors can help doctors characterise the disease in simpler terms, frame the patients' experience, and drive them towards a specific therapeutic pathway. These aspects are especially relevant in the case of chronic conditions, such as cancer and diabetes, where patients' compliance, education, and self-management are of central importance for healing.

Tripodi, in turn, analyses shortcomings in the communication from the patient to health professional. Medical diagnoses can be affected by how a patient describes her/his symptoms. Moreover, epistemic injustice can characterise this interaction, i.e., some groups (e.g., women and ethnical minorities) are statistically more exposed than others (e.g., men) to the experience of not being heard by doctors or health professionals. In other words, some people's epistemic authority tends to be systematically underestimated in the clinical context, and this can hinder the therapeutic process (on the notion of epistemic injustice see M. FRICKER, *Epistemic Injustice. Power and the Ethics of Knowing*, Oxford University Press, Oxford 2007). As Tripodi explains, this sort of epistemic injustice may be due to how different groups (e.g., men and

women) tend to describe their symptoms. According to previous studies, male patients generally present themselves as well-aware about their illness and potential treatment, able to observe their pain extensively, and to take their pain seriously (see J. VODOPIUTZ, S. POLLER, B. SCHNEIDER, J. LALOUSCHEK, F. MENZ, C. STÖLLBERGER, *Chest Pain in Hospitalized Patients: Cause-specific and Gender-specific Differences*, in: «Journal of Women's Health», vol. XI, n. 8, 2002, pp. 719-727). By contrast, female patients tend to favour an emotional self-description, to not take their pain as serious, and seem to be not particularly interested in knowing the cause of the pain. The solution Tripodi identifies is to review clinical practices in such a way to enhance the ability of patients to describe their symptoms and to make them aware of how important first-person experience is in this context.

The paper *Raising Awareness of How Asperger Persons Perceive Their Capacity to Use Metaphors* (ivi, pp. 129-136) by Lucia Morra exemplifies how beneficial philosophical perspectives might be to medical practices, too. The paper uncovers the relevance of linguistic analyses to our understanding of the *Asperger Syndrome* (hereafter, AS). Morra presents a selection of web exchanges among people affected by AS focused on how they understand and use metaphors in linguistic interactions (data come from the discussion forums of *Wrongplanet.net*, a web community designed for individuals affected by various conditions (e.g., Autism, Asperger Syndrome, Attention Deficit Hyperactivity Disorder) as well as for their relatives and health professionals). The data presented challenge the received view that misunderstanding metaphors is a distinctive mark of AS individuals when compared with neurotypical ones. Rather, the way people *in general* process metaphors depends on many variables (e.g., age, life experience, available information, context of utterance). As Morra suggests, it is well possible that the difference between neurotypical and AS individuals lies in one or more of these variables.

To conclude this first part of my review, in the paper entitled *Hopes and Limits of Moral Bioenhancement* (ivi, pp. 75-90), Maurizio Balistreri discusses an inherently ethical problem, i.e., the possibility of improving people's moral behaviour by intervening on their biology (e.g., through medical treatments, drugs, brain stimulation, or genetic engineering). For the sake of the argument, the author assumes that biotechnological advancements

will eventually make this possible. The question is: will this improve people's moral compass? Balistreri's answer is negative. The advocates of moral bioenhancement generally assume that virtue produces good consequences for the others, but no specific psychological state is necessary for this. In other words, what matters to them, is the external *behavioural outcome*. As Balistreri argues, this assumption seems to be problematic: although bio-enhanced people may be prevented from acting immorally, they can still have bad intentions. Biotechnologies could eventually attenuate negative emotions but, at the very least, we need to improve people's motivations and their ability to act morally *for the right reasons* – and this can be better achieved through social and educational strategies.

The distinction mentioned above between behaviour and psychological states leads us to the second major topic discussed throughout the issue, i.e., the relationship between the symptomatic expression of mental disorders and their biological basis. This relates to important ontological and epistemological questions, raised by Elisabetta Lalumera and Cristina Amoretti, surrounding the definition of mental disorder. The fifth edition of the *Diagnostic and Statistical Manual of mental Disorders* (DSM-5) advances a descriptive, symptom-based approach, according to which a mental disorder is a collection of symptoms associated with some psychobiological or biological dysfunction and significant distress (painful symptom) or disability (impairment in one or more important areas of functioning). The focus on symptoms, rather than on causal and aetiological factors, is intended to enhance the dialogue among scholars from different theoretical frameworks to psychopathology. Indeed, different frameworks can endorse widely different aetiological interpretations but, at present, there is no definitive reason to favour one over the other. As Lalumera says, «if the etiological basis [of mental disorders] were known, they could possibly be included in the characterizations of specific disorders. Given that they are not, descriptivism [...] within the criteria remain[s] the best options» (ivi, p. 117). In the paper «*Saving the DSM-5? Descriptive Conceptions and Theoretical Concepts of Mental Disorders*» (ivi, pp. 109-128) Lalumera outlines many criticisms towards the DSM's descriptive approach and defends descriptivism as a viable approach for contemporary psychiatry. By contrast, Amoretti, in her paper *The Concept of Mental Disorder: Between Definitions and*

Prototypes (ivi, pp. 57-74), highlights the limits of descriptivism and scrutinises some alternatives. Let us consider the two articles one by one.

To defend the DSM's descriptive approach, Lalumera takes classificatory systems as serving different purposes in different contexts. For instance, a system can be suited for diagnosis while others offer explanation or treatment. Importantly, in some contexts, the categories need to be *reference-fixing* (i.e., they need to refer to "real" entities) while, in other contexts, they do not. To clarify this, Lalumera introduces the distinction between *concepts* and *conceptions*. Concepts can be understood as corresponding to "natural" categories – the extension of which is identified by scientific theories. By contrast, conceptions can be understood as categorisation procedures or non-exhaustive points of view on the nature of the category. Notably, «what makes something member of a category (expressed by a concept) should not be confused with how we usually and preferably recognize it as such (the conceptions); in philosophical terminology, metaphysics should not be confused with epistemology» (ivi, p. 111). So, mental disorders correspond to *theoretically informed concepts* (possibly representing natural kinds) associated with descriptive *conceptions* that enable diagnosis and health communication. According to Lalumera, the problem with DSM is not descriptivism *per se*, but rather the use of diagnostic criteria to fix reference, which implies a conflation of conceptions and concepts.

The context-dependence of psychiatric categorisations is somehow present in Amoretti's paper as well. The author compares two alternative characterisations of mental disorder. On the one hand, the DSM defines a disorder as collection of symptoms reflecting some sort of dysfunction and usually associated with distress or disability (see the definition above). On the other hand, the prototypical view holds that disorders cannot be defined in terms of necessary and sufficient conditions. That is, the category membership does not depend on any specific property (e.g., a dysfunction), but rather on the overall similarity of an individual to the prototypical disorder under examination with respect to some relevant factor. Amoretti identifies various problems with both characterisations. For instance, the DSM's definition includes theoretical terms, such as "mental" and "function", that are not adequately clarified. The prototypical definition, instead, opens the door to

some sort of indeterminacy as it relies on the identification of *the relevant factors* accounting for the proximity of an individual to the prototype. But relevant to whom, and for what purpose? Since many human conditions share "relevant" commonalities with psychopathologies (e.g., sadness and major depression, shyness and social phobia), the prototypical approach seems to be unable to draw a clear-cut distinction between health and disease. Amoretti opts for a pragmatic way out and suggests that no single concept of mental disorder is capable of accounting for any purpose in scientific research and medical practices. Rather, different contexts require different conceptualisations of disorders, together with different classificatory systems. (A similar view characterises the Research Domain Criteria project, promoted by the US National Institute of Mental Health, which aims at developing a new taxonomy for research purposes. See <https://www.nimh.nih.gov/research-priorities/rdoc/index.shtml>).

The author concludes by submitting a "conceptually-clear" definition of mental disorder aimed at serving theoretical purposes – with no presumption of exhaustivity with respect to clinical objectives. According to this definition, mental disorders must involve some sort of dysfunction, i.e., the inability of a mental mechanism to perform its function and contribute to higher-order systemic capacities (or general goals) in a statistically typical way. Of course, as Amoretti admits, determining what the higher-order capacities of a system are, as well as what counts as "statistically typical", can depend on pragmatic choices and arguably is population- or environmental-specific.

To conclude, let me stress once again how important the interaction between ontological, epistemological, ethical, and practical aspects is in the study of living beings. An aspect highlighted in many of the papers reviewed is that health and disease can hardly be understood in terms of necessary and sufficient properties. This connects medicine and psychiatry to two important theoretical frameworks: first, the prototypes theory, addresses epistemological questions about how we tend to categorise the world (E. ROSCH, C. B. MERVIS, *Family Resemblances: Studies in the Internal Structure of Categories*, in: «Cognitive Psychology», vol. VII, n. 4, 1975, pp. 573-605); second, the *Homeostatic Property Cluster Theory*, coming from the natural kinds debate, investigates the metaphysical basis of scientific categories (see R.

BOYD, *Realism, Anti-foundationalism and the Enthusiasm for Natural Kinds*, in: «Philosophical Studies», vol. LXI, n. 1-2, 1991, pp. 127-148).

Both these theories, with their recent developments, point at the complexity of the biological world. On the epistemological side, the world seems to be too chaotic to expect humans to be able to categorise things in simple, essentialist terms. On the ontological side, the world seems to be too muddled to assume just one – and only one – way to “carve nature at its joints”. As many authors have argued in recent years, no medical nosology can identify purely mind-independent, value-free categories in the outside world: pragmatic choices and human interests are needed to specify what “joints” *matter to us*. At present, pluralism seems to be the only viable option – the burden of arguing the opposite should lie upon its detractors. However, no matter how philosophy of science will develop, understanding living beings requires undertaking interdisciplinary efforts, and this makes philosophy of medicine a complex and fascinating research field.

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