Education Grand Rounds
Westmead Precinct

February 24, 2020

Dr. Donald Boudreau
McGill University
Towards an understanding of the nature of wisdom in clinical medicine
Objectives

- to review how wisdom is commonly characterized
- to propose a conception of wisdom based on the understanding of the particulars of clinical cases
- (time permitting) to consider briefly how these notions might be further explored
Organization of the session

I. Conventional understandings of wisdom
II. Narrative review of the literature
III. Lessons learned from seminal texts
IV. Analysis of selected narratives from colleagues
V. Personal reflections
Wisdom:

“Capacity of *judging* rightly in matters relating to life and conduct; soundness of *judgement* in the choice of means and ends.”

Oxford English Dictionary
I. Conventional understandings of wisdom
• wise persons see the big picture
• wisdom requires good intentions
• wise persons are humble
• wise persons are able to maintain self-discipline while demonstrating enthusiasm
• wise persons avoid the extremes of ‘too confident knowing’ and ‘too cautious doubting’
• wisdom accrues with age
God
Grant me the
Serenity
to accept the things I cannot change;
Courage
to change the things I can;
and
Wisdom
to know the difference.

American theologian,
Reinhold Niebuhr
By three methods we may learn **wisdom**: First, by reflection, which is noblest; Second, by imitation, which is easiest; and Third by experience, which is the bitterest.

Confucius
II. Literature review
Method

A focused search of three computerized databases: - Embase, Ovid MEDLINE(R), and SCOPUS using the terms:
- clinical wisdom
- wisdom combined with clinician, physician, doctor or specialist
- practical wisdom
- phronesis
<table>
<thead>
<tr>
<th>Extraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>505 records identified</td>
</tr>
<tr>
<td>↓</td>
</tr>
<tr>
<td>after removal of irrelevant records,</td>
</tr>
<tr>
<td>465 records</td>
</tr>
<tr>
<td>↓</td>
</tr>
<tr>
<td>after application of inclusion &amp; exclusion criteria,</td>
</tr>
<tr>
<td>16 records</td>
</tr>
</tbody>
</table>
Insights from these articles:

Clinical wisdom is about:

• getting to know the unique personality of each patient
• understanding the goals, mandate, and limitations of medicine

In palliative care settings, wise practices include:
changing the approach from fixing to being with;
maintaining perspectives; maintaining boundaries
Nursing:
• integrating affect and intellect in problem solving
• being attentive to the individual while remaining attentive to the common good

Psychotherapy:
• using both conventional and non-conventional (or non-formulaic) methods
• being able to balance knowledge and doubt
• being detached and involved
• accepting paradox
The Berlin Wisdom Paradigm

Max-Planck-Institut für Bildungsforschung
Max Planck Institute for Human Development
Wisdom is expressed as expertise in the fundamental pragmatics of life

- factual knowledge about life (e.g. human nature, social norms)
- procedural knowledge about life (e.g. how to give advice, how to handle conflicts)
- lifespan contextualism
- relativism of values and life priorities
- recognition and management of uncertainty

Paul Baltes & Ursula Staudinger
As judged by these criteria, Baltes & Staudinger have found that many adults are “on the way towards wisdom” but very few display “a high level of wisdom-related knowledge.”

Wisdom does not necessarily increase with age.
How is wisdom in medicine generally conceived of these days?

1) Astute & accurate diagnosis
2) Exemplary bedside manners
3) Breadth of clinical knowledge
4) 'Aequanimitas'
5) Competence + ethics
Wise performance as ‘proficiency in diagnostic reasoning’
proficiency in diagnostic reasoning
III. Seminal texts
Ways of knowing or modes of reasoning according to Aristotle

<p>| Theoretical | Non-theoretical |</p>
<table>
<thead>
<tr>
<th>Theoretical</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>sophia</td>
<td></td>
</tr>
<tr>
<td>epistēme</td>
<td></td>
</tr>
<tr>
<td>nous</td>
<td></td>
</tr>
<tr>
<td>Theoretical</td>
<td>Non-theoretical (Productive &amp; Practical)</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>sophia</td>
<td>poiēsis</td>
</tr>
<tr>
<td>epistēme</td>
<td>technē</td>
</tr>
<tr>
<td>nous</td>
<td>phronēsis</td>
</tr>
</tbody>
</table>
Aristotle discusses (rather sketchily -- in Book VI of Nicomachean Ethics) the issue of practical reasoning. He calls it *phronēsis*.

*Phronēsis* = the capacity to deliberate well and to make good (acceptably appropriate) judgement calls, reliably and prudently (practical wisdom)
The phronimos start off with *relevant appearances* (i.e. knowing which ballpark one is in) and generates tentative hypotheses (they are aimed at *removing ignorance* – not necessarily solving the dilemma all at once).

They take into account opportunity, luck, and chance. They consider the complexity of individual cases, while not losing sight of general rules, norms, or guiding principles.

Through a process of deliberation, combined with a disposition to act in the right way, the phronimos decides on particular courses of action – in an acceptably

The action taken changes the person.
Oliver Wendell Holmes implies an assimilation of action to being when he says:

“Even the knowledge which you may be said to possess will be a different thing after long habit has made it a part of your existence. The tactus eruditus extends to the mind as well as to the finger ends”.
A popular tagline for Phronēsis

Combining knowledge of generals with experience-based rules of thumb so that the right person, does the right thing, to the right extent, at the right time, with the right aim, and in the right way.
Hunter defines clinical medicine as “a science-using practice that must diagnose and treat illnesses one by one.”

She describes the need for clinicians to cultivate a bifocal cognitive perspective: “Clinical reasoning in medicine has, of necessity, two aspects: generalization and particularization. These are opposite moves—lumping and splitting—and they alternate in tension as the reasoner moves between them......This counterweighing is the central characteristic of clinical judgment....”
Feinstein --- ‘father of epidemiology’ --- described, on the basis of a meticulous and comprehensive analysis of clinical phenomena, the elements constitutive of diagnostic and therapeutic actions. He focused on individual clinical cases, in their full complexity and inexactness.

He underlined the importance of identifying and measuring ‘ailment-related phenomenon’; it incorporated individualized (particularized) and population-based (generalized) clinical phenomenon.
A visual metaphor for the ‘particularization’ and ‘generalization’ process – the scatter diagram:
The ‘particular’
The ‘general’
Analysis of narratives from colleagues
Wisdom involves the **questioning of our basic assumptions**:

- “In an attempt to help, my judgement was clouded.”
- “Our role is to preserve and extend life as long as possible....[but] where do we draw the line in the absence of an absolutist orientation?”
Wise actions involve **rule breaking**; not being constrained by guidelines; trespassing boundaries:

- “Choosing to advise against a treatment that might be considered standard in a given context.”
- “Challenge the notion... of X.... ”
- “There is a certain passion and intensity that allows you to extend beyond the rules”
Wisdom is **getting the picture** quickly, having an eye to the situation, knowing which ballpark one is in. As Dr. G would often ask at Friday rds, “*In which chapter of Paré’s textbook is this?*”:

- “the story just didn't add up”
- “recognizing what the patient needs rather than just treating his condition”
- “recognizing a new issue”
- “formulating a new way of looking at and diagnosing a familiar disease”
When wisdom is a person

*Wisdom is Dr. X* ......because he/she attends to the biological AND to the psycho-socio-politico-cultural-financial.
When wisdom (and/or prudence) is lacking

- “Wisdom seems few and far between these days.”
- “We seek the patient's input into our decisions and are mindful to avoid being paternalistic, as we should be. But seeking a patient's opinion and view cannot substitute for good judgement or avoid the need to make a more difficult discussion. The physician's recommendations should accompany the options”.
- “There was always a notion that we needed to do the most invasive thing possible. Hence, there was rarely situations where we would say, ”No, we will not do that".
Personal reflections
Given that medical clinical decisions require
- mediation of the ‘general’ and the ‘particular’

*and that*

- universal theories cannot be applied to specific cases in a codified, protocolized, rigid rule-based manner
therefore, wisdom in medicine depends on -a flexible reading and application of general knowledge and a thorough, nuanced, on-the-ground understanding of the ‘particulars’ in medicine
Flexible reading of general knowledge......

- Be cautious with how you are informed by aphorisms

Occam's Razor: No more things should be presumed to exist than are absolutely necessary, i.e., the fewer assumptions an explanation of a phenomenon depends on, the better the explanation.

(William of Occam)

izquotes.com
• Be cautious with how you are informed by aphorisms
• Make flexible use of a few personal maxims (e.g. Colman Rules #1, #2 and #3; Boudreau’s 2nd Golden Rule)
Particularization

Working through and with cases is a path to medical wisdom......

**If p, then what? Thinking in cases**

*John Forrester*

---

**Case-Based Learning in Higher Education**

*John Branch, Paul Boudon, and Claus Regard*

---

**Penser par cas**

---

**Getting Down to Cases: The Revival of Casuistry in Bioethics**

*John D. Arras*
Features of a ‘particular’ (a case) in medicine

• one must be able to perceive & recognize a situation as a particular
• a particular occupies a region of space (i.e. a place); persists through time (i.e. it has a past, present, and anticipated future); has boundaries (e.g. bodies); has a context or environment; can be divided into parts (i.e. has peripheral and more central features)
• reasoning through cases necessarily includes reasoning about all characteristics of a person, not only the biological facts
Features of a ‘particular’ (a case) in medicine

• knowledge of particulars and how to deal with particulars are acquired through extensive experience

• from a patient’s perspective a case is never ‘ordinary’ or ‘routine’; especially at the stage when an illness may be incompletely understood. A wise physician will rarely utter: “This is only [merely/simply] a case of...X ...”

• describe the case thickly and richly; the multifaceted nature of a case risks being overlooked in the absence of comprehensive descriptions
Features of a ‘particular’ (a case) in medicine

- The description of a clinical case is not synonymous with the case itself; a case history is (at least) one-person—a narrator—removed from the actual facts of the case.
- A case description generally has a provisional aspect and is susceptible to revisions i.e. the case must be ‘rebuttable’.
- The understanding of a case may benefit from the advice of others i.e. pooling experiential clinical wisdom.
Features of a ‘particular’ (a case) in medicine

• thinking about cases is goal oriented; it must culminate in decisions or recommendations. In medicine, as in law and applied ethics, there is no ‘no decision’ option
• time can be used as a diagnostic and therapeutic tool (‘a tincture of time’)
• decisions require thinking about what is ‘right’ and ‘good’
One final thought

Recognizing and celebrating *menschlichkeit* in others can cultivate collective wisdom
Medical wisdom:
• is not equal to a broad knowledge base
• requires extensive experience (preferably in association with sage mentorship)
• is an aspirational goal; very few of us become *phronimoi*
• age does not guarantee its acquisition
• involves a ‘dance’ between generalization and particularization
• is aligned with *phronēsis*
• depends on a nuanced appreciation of particulars
Controversies & next steps

• Is the person who is wise medically necessarily wise in life in general?
• Can the clinician with excellence in techne be wise?
• Is there any difference between the ‘good’ and the ‘wise’ physician?
• How to further the research agenda?
• Can these concepts be translated into concrete pedagogical strategies?
Thank you!