On the Teaching and Learning of Clinical Wisdom

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This paper is based on the assumption that clinical competence includes a dimension beyond technological considerations. This dimension is sometimes called "art" but here has been termed "wisdom" in the hope that the latter word lends itself more easily to description. The components of clinical wisdom are explored in terms of assessment of the patient's personality as well as assessment and management of his problems. Behavioral objectives are defined which can be adapted to a curriculum for medical students or residents and can serve to identify and begin to measure the competency of clinical wisdom. These behaviors are observable and learnable, are to considerable extent quantifiable indicators of clinical wisdom, and are therefore legitimate concerns of medical education.

One of the highly prized but often incalculable attributes of a physician is that he or she be "wise." Clinical wisdom is more easily recognized than defined and is ordinarily attributed only to a few of one's actual professional acquaintances. Experience in practice seems to be one requisite but is not a guarantor. One is too often reminded of the cliche about "one year's experience twenty times."

As medical educators we secretly dare to hope for a modicum of wisdom among ourselves and fondly wish to see a promise of it in our students. Given the elusiveness of a clear definition, we usually settle for something a great deal less — a "safe physician" being one of the more frequent compromises. While a safe physician certainly is not to be eschewed in favor of a dangerous one, the expression seems too passive and negative to represent the higher achievement. "First do no harm" is a wise aphorism but it is difficult to think of the wisdom of an Osler primarily in such terms.

This paper will aim to distinguish clinical wisdom from clinical judgment, describe its component parts, and develop educational objectives for teaching this essential ingredient of excellent medical practice.

Clinical Judgment versus Clinical Wisdom

Clinical judgment and clinical decision-making are subjects of a good deal of writing but these do not capture the most important nuances of wisdom. The issues and assumptions about clinical judgment have been summarized concisely by Harty.[1] The book, "Clinical Judgment," by Feinstein represents a more exhaustive treatment.[2]

Mathematical and statistical models of the internal and logical processes used by a clinician in arriving at a diagnosis or predicting patient behavior have consistently compared favorably with the performances of physicians under experimental conditions.[3] Factors such as observer error, problems of inter-rater reliability and inconsistency of judgments by the same observer at varying times point to the fallibility of the clinician as a diagnostician. As a matter of fact, Antley and Antley have suggested that this role of the physician may already be in danger of becoming obsolete in

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favor of computers, automated laboratories and sonar diagnostic devices.[4] Should this futuristic and utopian state of affairs come to pass there will remain a critically important role for the *human* physician in the management of patients and their health problems. It is in this role that I subsume the concept of "wisdom." In fact, this role may turn out to be the unique and quintessential one. If this be so, we should by all means include the teaching of this role in our curricula. With this statement I am rejecting the notion that the "art of medicine" is so intuitive and peculiarly personal as to preclude rational analysis.

Component Behaviors of Clinical Wisdom

Assessment of the Patient's Personality

Every clinical diagnosis, except the most trivial and transient, should include an appropriate assessment of the patient's personality. This is fundamentally an interviewing skill. Kolb has commented that the interview is *the* most important technical instrument of all those professions concerned with man and his social functioning.[5]

The wise physician knows that it is not enough to determine what condition the patient has, but also what patient has the condition. Accurate personality assessment has relevance for all aspects of the clinical situation and enables the physician to make a number of informed decisions about management and to *predict* important characteristics of the developing doctor-patient relationship.

As a minimum the general physician should be adept at recognizing and dealing with obsessive-compulsive, hysterical, paranoid, passive-aggressive and sociopathic personalities in all their varieties. Issues of compliance, disclosure, seductiveness, dependency, hostility, scheduling of appointments and fee arrangements are all dependent variables that must be negotiated in every continuing clinical relationship. These can be handled effectively only if the physician knows with whom he is negotiating — and has some clear perceptions of his *own* personality. As in marriage, the ongoing clinical relationship operates under the terms of an informal "contract" that is often more powerful than the formal one. Clinical competence is more often at the mercy of the strictures of the informal contract than the fund of biomedical information the physician possesses. One can only guess at how often diagnoses are delayed, unnecessary and risky tests are ordered and inappropriate treatment prescribed because objectivity is subverted by unrecognized personality factors.

Assessment of the Patient's Problems

Notwithstanding the recent salutary emphasis on clinical record-keeping, the problem-oriented record and computer applications to clinical data, there are certain prior considerations that deserve emphasis in the interests of wisdom. It is apparent that simply changing the form of the record — or even improving its legibility — does not guarantee its validity or its congruence with actual events. I am among those who feel that "s.o.a.p.ing" the record often results in an impoverishment of significant details that cannot be incorporated easily into this format. Among these prior considerations I offer the following as necessary to wise practice.

1. *Ascertaining the Real Reason the Patient is Seeking Health Care.* This is what Feinstein referred to as the iatrotrophic stimulus, as opposed to the chief complaint. Two recent examples illustrate what is meant.

> A college student came to the health center three times within a month requesting a V.D. test. On the first two occasions the request was granted and negative reports given. On the third visit a wise physician engaged the student in sufficient interviewing to determine that a strong homosexual liaison was disintegrating and the student was using a medical-sexual metaphor in the hope that someone would discover this problem.
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> A 65 year old woman requested a "check-up" but was quick to reassure the physician that it was simply routine — she denied any health problems. It was only in response to persistent but gentle inquiry that she "confessed' that she had been taking amphetamine "diet pills" regularly for five years. She was feeling guilty and worried that the pills might be damaging her health.

Behind many chief complaints lurk a melange of fears, fantasies, myths and secrets that motivates health-seeking behavior which the physician must not ignore or fail to elucidate.

2. *Ascertaining the Patient's Rank Order of Priorities Among His Health Problems.* This dimension includes finding out how the patient has organized his concerns prior to the consultation, what rationalizations have already been made, what he thinks the trouble might be and how seriously he regards it. The patient rarely presents himself to a physician with no preconceptions about his health and it is imperative that the physician take these into account. Consider this example:

> A very apprehensive young secretary was under the impression (probably erroneous) that she had ulcerative colitis. She consulted a new physician because of intermittent diarrhea. In the course of the physical examination, a heart murmur was discovered. The patient, compliant but frustrated and angry, found herself in the midst of a cardiac diagnostic work-up which seemed to her not only irrelevant but cost more than she was able to pay.

This is not to imply that the murmur deserved no consideration but in relation to this particular patient it should have been evaluated after her priorities had been respected. Imposition of the physician's priorities on the pa-

tient is to be avoided by the wise physician except under circumstances described below.

3. *Establishing a Rank Order of the Patient's Problems in Terms of Clinical Importance.* The two component dimensions of clinical wisdom which have been described are but two of several which influence a more comprehensive ordering of the patient's health problems in terms of their overall clinical importance. In the course of interviewing and examining a patient, the physician may discover conditions of which the patient is unaware or devaluates inappropriately. These must be added to the list of problems in proper sequence for further study and/or management. Among other factors to be considered by the physician are the following.

Functional and organic elements: The wise physician has long since abandoned the dichotomy of body and mind that pervades much clinical thinking. He knows that an either/or attitude toward health problems leads to unnecessary and inaccurate conclusions, and that the real clinical task is to assess the proportion of organic *and* functional components in *each* case. The most difficult clinical problems always involve both. This is a liberating insight which allows the physician to value both sides of the equation and to avoid the obsessive search for organic factors of a low order of probability or importance. One can only speculate how often chemical diabetes, borderline hypothroidism, degenerative arthritis and other chronic stable conditions are seized upon as a way of avoiding a more difficult clinical task of identifying and dealing with a situational reaction or a depressive reaction. The wise physician knows that the "relief of discovery" of an organic diagnosis is soon dissipated and he will be called upon to produce additional diagnoses to "explain" the next recrudescence of symptoms.

On the other hand, the physician should not be deflected by functional complaints from recognizing potentially threatening conditions which require specific treatment. It has been demonstrated that patients diagnosed as manifesting conversion hysteria or depression have an incidence of organic diseases and death higher than in the general population.[6,7] This may be interpreted retrospectively as representing errors in the initial diagnosis or as indicating the frequent association of functional and organic conditions. In either case it behooves the physician to maintain objectivity, to avoid labelling patients uncritically and to be willing to reevaluate patients when new symptoms are presented.

Personal, social and economic factors: These factors may constitute clinical problems *per se* but more often function as modifiers of other problems. Medical practice always involves a series of compromises and negotiations that take into account reality factors in the patient's life which affect his ability to accept recommendations. The demands of work schedules, the limitations of finances and the impact on other members of the family often impose an order of their own on what the patient is able to choose. The timing of elective surgery, prescription of diets, limitations of physical activity, drug therapy and recommendations for psychotherapy must be tailored to the individual patient. Often this means tolerating delay, accepting ambiguity and modifying "textbook" therapeutic regimens on the part of the physician. *Wisdom is knowing when such compromises are feasible and when they are not.* It presupposes the clinician's ability to rank-order the patient's problems in terms of clinical importance and to focus on those which deserve top priority. Knowing that these decisions are neither trivial nor irrelevant is a mark of a wise practitioner.

Management of the patient: In perhaps no other aspect of clinical practice than management of the patient is wisdom manifest — management here being used as a more comprehensive term than treatment. This is attested by a long line of illustrious physicians from Hippocrates to present. The writings of Richards, Peabody, Houston and Fox form a curricular base that should be the foundation of all physicians' education in management.[8-11]

The first important principle is that management grows out of an appropriate relationship between doctor and patient. Peabody in 1927 set the tone, "The treatment of a disease may be entirely impersonal: the care of a patient must be completely personal . . . for the secret of the care of the patient is in caring for the patient."[9] Elaborating on this theme, Richards wrote, "But once a physician does take upon himself the responsibility for a patient's care, instantly he becomes a different man . . . suffering, moreover, is different from misfortune: it comes not in battalions, but by one and one. Each man's is his own."[8] Houston added an important reminder, ". . . the doctor's attitude toward the patient is perhaps more fundamental than the patient's attitude toward the doctor . . . the faith that heals is not through argument but by contagion."[10] Finally, Fox specified the therapeutic attitude, "But if the physician is so good a doctor as not to be put off by weakness, folly, grief or sin, or even bad manners . . . the relationship can be something invaluable."[11]

The consensus of these writers is that the physician's use of self in management is the critical ingredient. The proper use of self is far more technical and specific than simply having a good bedside manner or exhibiting common courtesy. It involves elements that must be learned and has goals that are as specific as any pharmacopoeia.

On the negative side, Fox said that a very important function of the personal doctor ". . . is to protect his patients from treatment they could do without — or would be better without."[11] On the positive side, Houston dealt at length with the proper use of the placebo. "The great lesson of history," he wrote, "is that the placebo has always been the norm of medical practice."[10] That placebos have been exploited and that physicians have sometimes used placebos inadvertently or unselfconsciously does not nullify their validity. The placebo response occurs in relation to all modes of therapy and restrains undue enthusiasm for all new treatments.

All this implies is that empathy is the *sine qua non* of clinical practice. The capacity to use one's own feelings to vicariously experience what the patient feels is a highly refined skill that the wise physician uses as adroitly as digitalis or delicate surgery. Empathy is not to be confused with in-

tuition, personal idiosyncratic reactions, identification or projection. It is a cultivated and refined use of one's reflective knowledge of human experience — one's own as well as others — coupled with careful listening, (termed by Ornstein as "evocative listening") that allows the physician to understand what it must feel to be in the patient's shoes. It is this perspective that allows for decisions about specific treatments, their potential benefit, risk and cost to be assessed objectively and honestly. This is the essence of clinical wisdom. To treat or not to treat is a question that can only be answered within the context of a therapeutic relationship.

Educational Objectives for Teaching Clinical Wisdom

It is my conviction that clinical wisdom can be taught, evaluated and improved. The following behavioral objectives lend themselves to evaluation as adapted to various levels of sophistication of medical students and residents.

1. Given simulated or real patients in a clinical setting, the student will correctly identify, by means of personal interviewing, five personality types according to criteria established by psychiatric faculty:
   a. obsessive-compulsive
   b. hysterical
   c. paranoid
   d. passive-aggressive
   e. sociopathic
2. Given five patients of these personality types, the student will describe orally or in writing:
   a. the "core" dynamic conflict in each type
   b. prediction of the issues and behaviors that must be negotiated in order to establish a therapeutic relationship with each type
3. Given a real or simulated patient, the student through interviewing will elicit and identify the iatrotrophic stimulus and defend his interpretation to a faculty supervisor who either has programmed the patient or who will corroborate or deny the interpretation with the patient.
4. Given a patient with multiple health problems, the student will, after appropriate interviewing and physical examination, construct two lists of problems in order:
   a. the patient's priorities
   b. the clinical and therapeutic priorities according to the degree of threat each problem poses to the patient's life or functional ability.
5. Given a patient with a conversion symptom or psychophysiologic reaction, the student will design and implement, under supervision of a faculty member, a therapeutic strategy that includes the use of placebo medication for a period of not less than three months.
6. Given a patient as above (5), the student will design and implement, under the supervision of a faculty member, a therapeutic strategy that does not include the use of medication for a period of not less than three months.
7. Given a patient with a chronic, active clinical disease process such as peptic ulceration of the gastrointestinal tract, rheumatoid arthritis, recent onset of diabetes mellitus or diffuse hyperthyroidism, the student will design and implement a comprehensive plan for management appropriate to the patient's psychological status, social class and economic condition as agreed upon with a faculty supervisor. The plan must take into account the patient's need for:
   a. drugs
   b. diet
   c. exercise and rest
   d. support
   e. environmental manipulation
   f. consultation
   g. role of co-professionals and/or allied health persons
8. Given a patient with an indication for elective major surgery, the student will carry out, under supervision, the following clinical tasks:
   a. Explain the need for surgery and establish the patient's acceptance of the need.
   b. Negotiate the scheduling of the procedure.
   c. Obtain appropriate surgical consultation.
   d. Prepare the patient for the procedure in terms of informed consent, anticipated time sequences for hospitalization and convalescence, and costs.
9. Given a patient with a depressive reaction or chronic anxiety, the student will demonstrate the use of empathy in a supervised interview, and afterward discuss his feelings towards the patient in a way that indicates his ability to distinguish empathy from idiosyncratic personal reaction, identification and projection.

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