Practical wisdom; vital core of professionalism in medical practices

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The subject of this PhD-thesis is practical wisdom, "… the virtuous capacity to … discover what is morally relevant, knowing how to decide, knowing how to act, as well as knowing how to learn from what was not done well. Professionals with practical wisdom are always able to discern what is general and what is specific in nature (and act accordingly)" (Vosman, 2008). In particular, the thesis concerns practical wisdom in everyday medical practices that are pervaded with morality i.e. that they are focused on enacting the good for each individual patient.

Marij Bontemps-Hommen, pediatrician and member of the research network Critical Ethics of Care, presents a summary of the results of her PhD thesis.

Practical wisdom in everyday medical practice

Practical wisdom has become a problem in our late modern society because of its increasing complexity, its accelerating developments, associated uncertainties, and the disappearance of familiar ideologies and conceptual frameworks. Moreover, the dominant neo-liberal discourse that has replaced trusted views enabled an overvaluation of technologies and instrumentalism in the professions. My assumption is that practical wisdom has therefore become indispensable in professional practices, but at the same time the outlined developments suppress practical wisdom.

The specific questions that guided my investigations generally revolve around the following problems: what is practical wisdom, how does it emerge in daily practices, what inhibits and what promotes practical wisdom, why is it desirable and what happens when it is missing, can it be learned and how does it contribute to good care? To answer these questions I conducted a number of empirical studies – field research – closely observing practices of medical specialists in general hospitals. Given the results of the research, the interaction between theory and practice occupies a central place in my research, as does the meaning of practical wisdom for the medical profession, to the further development of which I am happy to contribute.

Conducting the study

The endeavor to observe practical wisdom gave rise to a difficulty: practical wisdom is not directly observable and certainly not quantifiable. It has probably been insufficiently themed and operationalized through a primarily theoretical approach to date. But, it can be *inferred* from the observations in empirical studies. Besides, assessing the meaning of practical wisdom for enacting morality within a practice demands an interpretive step. This is why the empirical study I wanted to perform, had to be of a *qualitative-empirical nature*.

I have conducted the study from a *care ethical perspective* on care and care practices. In empirical studies into clinical practices, especially its characteristics of *relationality* and

situatedness or *contextuality* emerge, to a lesser degree the political-ethical aspect of care ethics, although this always constitutes the overarching framework.

In addition, I have worked out that, by studying practices and not individuals or individual actions, I follow specific practice theories, as described by among others Nicolini (2012) and Schmidt (2012). Nicolini and Monteiro (2017, p. 2) have defined practices as "… orderly materially mediated doings and sayings ('practices') and their aggregations." For the empirical research, this practice approach meant that I have studied what was going on within the setting examined as completely as possible: being its social (the interactions and interaction patterns) and physical elements (being ill and vulnerable for patients; the legitimized invasion of a patient's physical integrity by practitioners); besides, material elements (the patient's files, the electronic information and exchange of information), institutional, structural elements (whether or not there is regular multi-disciplinary consultation; recording the lessons learned; structural preparation and subsequent discussion after a consultation) and the culture of work and cooperation (is it hierarchical, top-down, or supportive, sharing and exchanging, respectful etc.). Furthermore, I have tried to elucidate the influence of the practice, which has been studied as completely as possible, on the emergence of practical wisdom.

Also, I have studied practices *from within or bottom-up*. I have done this through observation where possible, but direct observation was not possible in all studies. In three out of four studies, I have chosen for observation through a 'window' (in the form of detailed mediating data), which in retrospective, enabled a very detailed and specific insight in the practices studied. The specificity made it possible for me to look in the same direction as the professionals I have studied, and thus, I could take up their perspectives. Furthermore, the expectation, that this view from inside would illuminate other aspects of practical wisdom than the features highlighted through theoretical viewpoints from outside, proved to be right.

Theory and methodology

The second chapter of the thesis discusses theoretical studies on the most important concepts used in the empirical studies: complexity and complexity science; care ethics; practice theory; phronesis and practical wisdom. I have formulated a tentative, heuristic definition of practical wisdom here: "*practical wisdom is the capability which emerges in acting jointly within medical practices, of knowing how to remain focused on achieving the good for every individual patient, in ever-changing situations, within the context of the practice and its telos, and of how to accomplish this by the most appropriate means, while dealing with complexity and institutional and systemic pressure".*

Chapter 3 comprises an account of the methodology of the four empirical studies which are described in the chapters 4-7. The empirical studies always had a dual purpose: on the one hand, they are the empirical research from within existing practices and on the other hand, I use the results for a critical approach to my own definition and then to question the existing theories of practical wisdom and also the theoretical frames that I have used.

Faces of practical wisdom

Chapter 4: *'The multiple faces of practical wisdom in complex practices'*, is a report of the

qualitative-heuristic analysis of thick descriptions of 10 very diverse patient cases. I provided a survey of the various *manifestations of practical wisdom* that I observed. I have found *patterns* such as: 1) a meandering instead of a linear work routine; 2) attuning the available means (e.g. guidelines) to the patient through improvisations; 3) getting the timing right for the patient; 4) taking advantage of different sources of knowledge; 5) actively maintaining, repairing or consolidating professional relationships. Moreover, I found various *'interruptions'* or disturbances (of workflow and routines; of the doctor-patient relationship; of physicians' (work) conditions; of patient's characteristics) of which it has been suggested that they are able to trigger or encourage the emergence of reflection and practical wisdom (Frank 2012). Reflection and practical wisdom did not automatically result from these interruptions. I was only able to investigate to a certain extent my assumption that the triggering of practical wisdom could be facilitated or obstructed by specific *'figurations'* of the work structure. Figurations are networks of human and non-human, material and immaterial, interrelated and interdependent factors, which constantly adapt in dynamic processes. Finally, I reached a few unexpected insights, such as that *professionals' awareness of the good* (the telos) is the essential point of reference for practical wisdom, and that practical wisdom as *'doing wisdom'* takes seemingly *trivial, commonplace forms.*

Can practical wisdom be learned?

In chapter 5, *"Professional workplace-learning. Can practical wisdom be learned?"* I investigated whether practicing medical specialists learn practical wisdom through regular joint case discussions that are focused on a general learning objective. Therefore, I studied the reported 'lessons learned' of 100 multi-disciplinary discussions of medical staff about complex patient cases in a general hospital. The discussions had taken place during a twelve-year period. This study did not offer any insight into medical practitioners' individual learning. However, it did demonstrate social learning (in medical practices) and organizational learning (in the hospital organization) of practical wisdom. Social learning emerged as 1) *increased awareness and recognition* of the four components of practical wisdom (telos, balance, judgment and reflection/reflexivity); 2) *increased reflexive capability*; 3) *recognition of the morality* of medical practices in mundane, multiform shapes (for example: postponing an operation to help the patient prepare better for the risks she was likely to run, or deciding not to apply physical restraints to prevent falling, because the disadvantages of restraints for a specific patient are disproportionate to that risk); 4) *implicit or tacit knowledge* of practical wisdom (Nonaka & Takeuchi, 1995; Polanyi, 1969; Vosman & Baart, 2008), i.e. 'practical wisdom' was not mentioned explicitly anywhere; 5) *distributed intelligence* (Iedema, Mesman & Carroll, 2013*)/distributed wisdom:* practical wisdom was 'crystallized' in *the physicians' mores*. Moreover, the practical wisdom derived from the case discussions *emerged in the structure and culture of the hospital organization,* as the impact research showed. In that sense, there had been *organizational learning of practical wisdom* (Minzberg, 2012; Schwarz, 2011; Vriens, Achterbergh & Gulpers, 2016). Examples of organizational learning as structural changes are: the hospital created 'reflective spaces' (opportunities for joint deliberation and reflection); the hospital performed an accredited training for hospital specialists (generalists). Examples of organizational learning as cultural

changes are: a competitive culture of professionals changed into a culture of professionals supporting each other; the capability to constructively discuss sensitive issues was developed.

Suppression of practical wisdom: the dominant professional discourse and the hospital infrastructure

In chapter 6, *"Professional medical discourse and the emergence of practical wisdom in everyday practices. Analysis of a keyhole case"* I studied a patient case that was complex, in which multidisciplinary care had to be provided for a long period, of which documentation was complete and which could be studied along different lines. I investigated 1) the ratio between the phronetic and technical-systemic approach to a case within the medical practice of a training hospital, 2) the influence on this ratio of the dominant discourse and of the care organization and 3) their effects on the care given and on cooperation between the various professionals. I found an asymmetric ratio between the technical-systemic approach (which uses protocols, guidelines and routines) and the phronetic approach, with the former being the dominant approach. The factors that occasioned the asymmetric ratio were partly *practice-bound*, like the *dominant (medical-technical) discourse*, with the following characteristics: 1) it is primarily focused on the patient's body; hence, it is a discourse of the body; 2) it is concentrated on the sick organ and on the disease, not on the patient as a whole person; this means it is a reductionist discourse; 3) it is medically and technically sound, but it trivializes the patient's context; it is a discourse lacking context; 4) it is mainly directed toward short-term continuity, but pays much less attention to the long term; 5) it suggests that cooperation with colleagues is established as the total of tasks carried out successively or alongside each other - thus, the discourse compartmentalizes and fragments; 6) it is also a hierarchical discourse, in which the physician is at the top of the hierarchy (and so has the natural power) and nurses and paramedics are lower down: the doctors give the orders and determine the relevance of information; 7) it includes a model of communication with patients and relatives, that is known as the informative model (Emanuel & Emanuel, 1992), in which the sender, the doctor, determines what is important and in which information is often communicated after the fact. Neglecting the knowledge of paramedics, patients, and relatives, as points 5 and 6 illustrate, corresponds with what Fricker, 2007, has described as *"epistemic injustice": "a wrong done to someone specifically in their capacity as a knower"* (Fricker, 2007, p. 1). These characteristics mostly fit the construction of reality of a traditional medical professional discourse, which has been characterized as paternalistic (Freidson, 2001; Tonkens, 2008) or as predominantly medical-technical, because observations and actions are mainly guided by medical-technical rationality (Dunne, 1993; Kinghorn, 2010; Schön, 1983). Furthermore, it presupposes a linear, certain, and uniform reality, instead of one that is complex, uncertain, and variable (Kinsella & Pitman, 2012).

The factors that occasioned the asymmetric ratio were partly *characteristics of the infrastructure* of the hospital. Examples of infrastructural suppressing figurations are: large numbers of professionals and large numbers of patient transfers; bilateral professional consultations exclusively; strong hierarchy and inequalities between professionals; material factors, such as the format of the electronic patient record; lack of reflective spaces; lack of arrangements to guarantee continuity of care in relation to patient transfers; lack of traditions surrounding contacts between professionals and patients/relatives. I was able to identify the

devastating *consequences* of the suppression of practical wisdom, for example growing *reciprocal estrangement*, *loss of trust*, *mutual misunderstanding* and *conflict* between the professionals and the patient's relatives. My suggestion is that practical wisdom could have prevented, minimized, or solved at least some of these consequences.

Practical wisdom in an out-patient clinic for adolescents with type 1 diabetes mellitus

In chapter 7, *"Making the best of it: practical wisdom in professional care for adolescents with type 1 diabetes mellitus",* I examined how practitioners struck a balance between knowledge of patients, moral norms and individual objectives on the one hand, and general guidelines, medical standards and ideal goals on the other, through participating observations of an out-patient diabetes clinic for adolescent patients.

I found that *a balance appeared to be struck* regularly in this practice between the acquisition and use of knowledge (general as well as specific), dealing with standards/norms (for medicine and life), and defining (sub-)objectives (ideal and realizable ones). I also found that the 'internal logic'(Mol, 2006) or the 'grammar' (Eikeland & Nicolini, 2011) of the practice lies in relationality and practical wisdom.

I subsequently looked at how the professionals and the team, supported by the infrastructure, enacted relationality and practical wisdom. The team, with characteristic mutuality, turned out to be important as a context in which mutual reflection and consultation were possible on the basis of equality; it also facilitated ad hoc informal or crisis meetings, and offered support for difficult decisions. The professionals had developed and honed the infrastructure of the practice over many years so that it optimally supported relationality and practical wisdom. In addition, relationality emerged in 1) the *structure and content of the consultations*. It was striking that professionals were guided by the patient's perspective, or 'concern' (Sayer, 2011); this became clear, among other things, from the fact that they were willing to discuss matters that were unimportant from a professional point of view, but that patients worried about. 2) In addition, relational work turned out to be translated into action routines and work structures. 3) Finally, the practitioners had developed a specific, flexible attitude, in which they easily attuned their approach to the specific patient they were seeing (directive, stimulating, compassionate etc.).

Practical wisdom emerged preeminently as 1) the *ability to determine,* sometimes in an instant (intuitively and creatively), *what is good for the patient*, what the patient needs to continue her life. 2) In addition, it appeared as *the ability to individualize* medical standards and the objectives of the guidelines. Individualization was realized by *estimating the bandwidth within which it was deemed acceptable to deviate from the medical norms without harmful consequences for the patient.* This involves *determining the margins of the bandwidth.* 3) Practitioners and the team both need *the ability to judge* to be able to perform this task (Kaldjian, 2014; Montgomery, 2006). 4) Individualization was also evident in *judging the hierarchy of norms,* with moral norms sometimes being placed alongside and sometimes even above medical norms. Practical wisdom emerged in the ability to compromise between skirting the norm and crossing critical limits (Mesman, 2002; Saraga, Boudreau, & Fuks, 2019). 5) In addition, *adapting the excellent objectives* of the guidelines to objectives that are judged to be *feasible* for a specific individual appeared to be a manifestation of practical wisdom.

Reflections and conclusions

In chapter eight I reflect on the four empirical studies and the theoretical premises of the study as a whole. I also present the conclusions of the research. On the basis of the empirical findings, I 'talk back' to the literature and present a well-founded description of practical wisdom. I subsequently reflect on the meaning of this research for other medical and non-medical professional practices and make suggestions for further research.

First, I have investigated the conclusions that arise when the results of the four studies are interrelated at a higher level: overarching conclusions. These conclusions are as follows: 1) *Practical wisdom involves interconnected reasoning and actions: practical reasoning and ordinary actions. 2)Interruptions replace dilemmas as 'initiators' of practical wisdom in daily work..* 3) *Multiform, changing figurations facilitate the emergence of practical wisdom; business-like, linear management and planning impede it.* 4) *Practical wisdom (phronesis), skills (techne) and basic sciences and evidence (episteme) partly overlap and have fuzzy boundaries.* 5) *Practical wisdom and relationality are interrelated and interdependent.* 6) *Practical wisdom is enacted morality, in contrast to practical wisdom as the (master) virtue.* 7) *Practical wisdom emerges in practices and organizations, not just in individual actions.* 8) *Practical wisdom is an essential part of professional moral logic.*

Second, I have adjusted the heuristic definition of practical wisdom, grounded in the empirical research: *Practical wisdom of medical practices is the capability which emerges in joint actions, that incorporate the grammar of good care and are aimed at discerning and focusing on each particular patient's good, that is also in accordance with the telos of the practice, in a dynamic process, using the most appropriate means, while dealing with complexity and with operational and systemic pressures.*

Third, I have answered the question, to what extent the results of observations of long-term admission to hospital, or outpatient care for adolescents with a chronic condition, are transferable to *other forms of medical specialist care in hospitals*, such as acute care (ED, ICU), care for patients with a psychiatric disease, or for patients with a simple, clear problem. Equally, I elaborated on the question as to what extent the results of ten or a hundred cases gathered in a general hospital are transferable to other settings, such as first-line healthcare, or rehabilitation care, or care for the elderly. The answer is that transferability depends on the *similarities* between these forms of care, particularly when care is given in settings with significant differences. I contend that there are similarities on a meta-level: in all kinds of settings, professionals work together in groups; all kinds of settings call for reflection and reflexivity must find a way; in all kinds of settings, professionals must judge and determine together with their patients what the good is that has to be enacted, and how the enacting can happen; in all kinds of settings, professional relationships must be established and used to give good care. There are thus *significant formal similarities*. The precise way in which practical wisdom can possibly emerge, may be different in other settings, but the specific examples described in our research can nevertheless, because of the similarities on the meta-level, support the performance of practical wisdom in those practices.

Another important question is whether the results are transferable to *other professional practices*, such as the fields of justice, education, nursing, management and governance of organizations. Here too, professionals must themselves identify the similarities between

medical practices and legal, educational, managerial etc. practices, to ensure that the results are transferable. General lessons from our research can possibly help; for instance, seemingly neutral issues, self-evident assumptions and rules contain hidden, implicit choices and value judgements upon which professionals should critically reflect, and which can be changed (see for instance the implicit choice favoring the dominant medical-professional discourse in chapter 6). I have called reflection, that includes critically judging and transforming practices, *reflexivity* (with Iedema, 2011; Kinsella & Pitman, 2012, and Kemmis, 2012). It is connected with practical wisdom. In his explanation of reflexivity, Iedema emphasizes that it mostly reflects *social, joint reflection*, aimed at conduct and situations in the here and now. He has underlined that attempts to comprehend and modify a practice with the help of reflexivity will have the best chance of success if the infrastructure within which they take place is open to such reflexivity and thus to learning and changing. This study also bears this out, as it has identified figurations that promote or hamper practical wisdom. Recognizing such figurations also offers possibilities to change them. Another general lesson is that in each of the professions mentioned, general rules must be attuned to individual people in specific situations and that the professionals in question must establish a certain bandwidth, including its borders. These borders determine when compromising on the rules involves unacceptable risks for a client or the unacceptable stretching of a norm (see chapter 7).

The discussion of the transferability of our research findings also shows the practical relevance of this study. Specifically, the study is relevant because it shows that it is essential for professionality to 'embed' practical wisdom in training and in daily practice. This has been demonstrated through analysis of the practices of medical specialists in hospitals, but this finding can be transferred to the practices of physicians in other settings, as well as to other kinds of professionals because the problems to which practical wisdom is a response also arise there. All professions can benefit from the promotion of reflection and reflexivity on the work. And, analogous to *jurisprudence* in legislation, forms of *mores prudence* for professional ethics (Van Doorn, 2008; Kanne & Grootoonk, 2014; Buitink, Ebskamp & Groothoff, 2019) should be gathered, made transparent and discussed in broad professional forums. In this way, discussions about morality in daily practices, like discussions about evidence, could become common practice, allowing for the further development of the practical wisdom of professional work and of professional practices.

I expect that implementing the given suggestions for further research on this issue will not only increase the attention that is given to the practical wisdom of professionals, but above all cause practical wisdom to develop in all kinds of practices. This research has convinced me that more practical wisdom can lead to better quality of care, i.e. care that it is better attuned to the individual patient. Also, that it can contribute to a better life for patients with a chronic or terminal disease, and, finally, to greater happiness for professionals who have the meaningful but difficult task to perform their profession together, competently and wisely.

The thesis is expected to be defended on October 26th, 2020. Professor Andries Baart will act as Supervisor, originally being the second Supervisor of this thesis. Yet he now will stand in for professor Frans Vosman, who unfortunately has left us much too soon.

References

Dunne, J. (1993). *Back to the rough ground: 'phronesis' and 'techne' in modern philosophy and in Aristotle.* Notre Dame: University of Notre Dame Press.

Eikeland, O. & Nicolini, D. (2011). Turning practically: broadening the horizon. *Journal of Organizational Change Management.* 24 (2), 164-174.

Emanuel, E.J., & Emanuel, L.L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association,* 267(16), 2221-2226.

Freidson, E. (2001). *Professionalism: the third logic.* Chicago: Chicago University Press.

Fricker, M. (2007). *Epistemic injustice. Power and the ethics of knowing.* Oxford: Oxford University Press.

Iedema, R., Mesman, J., & Carroll, K. (2013). *Visualising health care practice improvement: innovation from within.* London: Radcliffe Publishing Ltd.

Kaldjian, L. (2014). *Practicing medicine and ethics: Integrating wisdom, conscience and goals of care.* Cambridge: Cambridge University Press.

Kinghorn, W. A. (2010). Medical education as moral formation: an Aristotelian account of medical professionalism. *Perspectives in Biology and Medicine,* 53(1), 87-105.

Kinsella, E. A., & Pitman, A. (Eds.) (2012). *Phronesis as professional knowledge: practical wisdom in the professions.* Rotterdam: Sense Publishers.

Mesman, J. (2002). *Ervaren pioniers: omgaan met twijfel in de intensive care voor pasgeborenen [Uncertainty in medical innovation: experienced pioneers in neonatal care].* Amsterdam: Aksant.

Minzberg, H. (2012). Managing the myths of health care. *World Hospitals and Health Services,* 48 (3), 4-7.

Mol, A. (2006). *De logica van het zorgen: actieve patiënten en de grenzen van het kiezen [The logic of care: health and the problem of patient choice].* Amsterdam: Van Gennep.

Montgomery, K. (2006). *How doctors think: clinical judgment and the practice of medicine.* Oxford: Oxford University Press.

Nicolini, D. (2012). *Practice theory, work and organization: an introduction.* Oxford: Oxford University Press.

About the author

Marij Bontemps-Hommen (1948) is a pediatrician. She has practiced in several general hospitals from 1980-2016. From 1996-2016 she was a member of the pediatric group in St. Jansdal Hospital in Harderwijk. Also in this hospital she was a member and chair of the Hospital Board from 1997-2008. She was interested in the issues of quality, safety and ethics of care. Therefore she designed a practical ethics course for care providers. She was impressed by the ethics of care, and the promising concept of practical wisdom and therefore she decided to study practical wisdom empirically and theoretically. In her thesis she focuses on the relevance of practical wisdom for the morality of everyday medical work

Marij Bontemps-Hommen is married. She and her husband Jacques have three children and five grand-children. They are happy to have been able to care for them; in educating she also has experienced the need for practical wisdom.