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"Embarking on a study looking at the enactment of Phronesis (Practical Wisdom) in General Practitioners – The EPGPS"

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Abstract

This paper will explore the meaning of phronesis as applied to medical practice. Phronesis is an intellectual virtue, particularly suited to the work of the General Practitioner, where uncertainty prevails. The dominant positivist approach to the practice of Medicine operates on a level of predictive probability guiding the clinician's knowledge. General Practice defines itself in terms of relationships and the co-construction of knowledge.

Phronesis will position itself as an under-appreciated intellectual virtue in medical practice (McIntyrean holistic definition versus Aristotle's 'moral adjudication'). The paper will look at the background theory surrounding code-based moral frameworks that underpin medical education, including their shortcomings.

The paper will be written in context of PhD research that will be conducted over the coming months. This research aims to look at what enacted phronesis looks like in a population of General Practitioners (Family Medicine). The paper will introduce the planned research methods which include Ardelt's 3D Wisdom Scale, narrative interviews and NHS appraisal portfolio analysis. It is hoped the three methods will offer some triangulation in coming closer to identifying the

characteristics of a Phronimos in the General Practice setting, providing some empirical research that may guide the future direction of Medical Education.

Introduction

Aims of PhD research

The aim of the PhD research, which provides a backdrop to this seminar paper, is to provide some empirical research on enacted Phronesis. It will use a validated wisdom tool (Ardelt 3D Wisdom Scale), conceptually mapped to a virtue ethics concept of phronesis, to identify general practitioner (family medicine) exemplars. These exemplars will be studied further, exploring their attitudes, behaviours and heuristic approach to professional practice. This will be achieved by performing narrative interviews and triangulating data by a systematic analysis of the doctor's GMC appraisal/revalidation or training electronic portfolio. This process aligns with established research methods used in studying expert performance (Ericsson et al., 2006) and wisdom (Gluck et al., 2013)
It is hoped that by identifying themes in apparent enacted Phronesis, useful information will be gleaned that can inform future medical education approaches; for example by highlighting the importance of certain metacognitive skills, desirable clinician character attributes, complex decision making deliberations and information on their motivating drive and outlook.

Personal motivation

I am a female, British-born and educated, Indian origin doctor. I am blessed with some insight into eastern and western mind-sets towards intellectual and wisdom attainment, sometimes noticing the disdain that one approach has for the other, but also appreciating the benefits of both.
I have a passion for medical education and throughout my medical training I have reflected on how things could have been improved; contemplating on where the focus should have been shifted and where energies should be directed when it comes to rearing knowledgeable healers - wise doctors, as a result I have developed a fascination for the metacognitive aspects of learning.
It was not necessary for me to know, at the beginning, what Phronesis meant to identify that something was (and is) 'missing' from medical education and subsequent medical practice. Coming across its meaning just enabled a concept, or rather an intuitive feeling, to be labelled and therefore studied further.

Twenty years of medical practice may not seem like very long, but my reflections pre-date the commencement of my career. I belong to a lineage of medical practitioners going back at least three generations, across different continents. Technologies may have made previous knowledge unrecognisable, in fact clinicians' now suffer with information overload, but there is something else at the core of good medical practice. My experience is not unique, I have educational leadership responsibilities for the quality of GP education and foundation doctor training. Recurrent problematic issues lend themselves to some form of academic exploration of what being a wise doctor really means. For me, seeking wisdom is the ultimate continuing professional (and personal) development.

"We are drowning in information, while starving for wisdom. The world henceforth will be run by synthesizers. People able to put together the right information at the right time. Think critically about it and make important choices wisely".
E.O Wilson. Harvard biologist, Consilience: The Unity of Knowledge (1998)

This status quo lays the foundation for commenting on the present state, developments and controversies, providing opportunity to look at current research on professional development and areas of empirical weakness.

Present state

Positivism has become medicine's dominant philosophy since the early 19th Century. Positivism is a form of empiricism as established by Augustus Comte. It rejects metaphysics, objective (cognitively grounded) morality and theology and holds that experimental investigation and observation are the only sources of substantial knowledge. This is not a wholly bad thing as scientific thinking and beliefs have enabled evidence based medicine (EBM) to revolutionise healthcare and strengthen the professional class (Hilton and Southgate, 2007). Reeve feels it is better suited to secondary healthcare provision (Reeve, 2010), where populations are more predictable and poly-morbidity is less of a complication compared to family medicine. Misslebrook (Misslebrook, 2001) and Reeve suggest that the problem with EBM is that it is simplistic, a reductionist science. It can only work by restricting our gaze in the search for evidence. Having restricted our evidence to the biomedical, we then restrict our analysis and our guidelines to this model. Misslebrook goes on to advise that we need to guard against biomedicine becoming a means of social control, whether for the benefit of doctors or of politicians. Reeve refers to this social control as Scientific Bureaucratic Medicine (SBM).

Reeve would like to see the gaze shifted from easy to measure, limited accounts of practice to a more holistic assessment of practical knowledge (pg17).
Misslebrook observes that Western medicine is essentially about fixing things. This mind-set is encapsulated the 1948 WHO definition of Health:
"Not merely the absence of disease or infirmity, but a state of complete physical, mental and social well-being".
I am in agreement, in that this seems to be an unattainable nirvana which sabotages medical practitioners' attempts at feeling any sense of achievement (especially in the family medicine setting), never mind a constant drain on public resources. A more achievable and realistic goal would be to aim for flourishing, despite obstacles. This can be captured in Dietrich Bonhoeffer's (1906-1945) Definition of Health:
"The strength to be…the ability to pursue our own life story without the insurmountable obstruction from illness."
Healthcare should aim for the state of least possible illness or disability, thus redirecting the purpose of biomedicine, helping people to be well rather than telling them they are sick.
This fundamental premise would contribute to the flourishing of both the clinician and the patient. (Toon, 2014)

Interpretive Medicine (IM)

"I acknowledge the power of positivist science to describe and predict our world. However, Limitations should be recognised, and general practitioners be not only 'allowed', but supported and valued for their capacity to use a range of knowledge in the individualised assessment and management of their patients" Reeve (2010) preface.

Reeve (Reeve, 2010) speaks of EBM and SBM operating on a level of predictive probability guiding the clinician's knowledge. She speaks of it's worth, but goes onto to describe how unsuitable it is for the demands of General Practice (Family Medicine). Her paper argues that Interpretive Medicine (IM) is a more appropriate approach to looking at health care provision for the generalist. She describes IM as:

"The critical, thoughtful, professional use of an appropriate range of knowledges in the dynamic, shared exploration and interpretation of individual illness experience, in order to support the creative capacity of individuals in maintaining their daily lives".

Her paper concludes by suggesting we need to encourage educational support structures to help develop IM. She refers to the intellectual virtues as described by Aristotle as a means of delivering IM (p 11). Reeve's conclusion suggests that Phronesis should be developed as a marker of quality in General Practice (an intellectual discipline), specifically the ability to integrate knowledges to provide individualised care. Hutson and Myers (Hutson, 1999) argue that a Phronetic approach is also well suited to the practice of Medicine in developing countries where physical and financial resources are severely limited. This focusses on deliberations about justice and equity for populations in parallel to decisions about individualised care. In the current climate of austerity measures affecting the NHS this is also a relevant consideration.

Phronesis – An intellectual virtue

Toon, in his book 'A Flourishing practice' (Toon, 2014), introduces the term Phronesis as cardinal virtue that involves a particular judgement for a particular circumstance. Toon asserts that the cultivation of virtue should be the centre of medical education, the current focus being on gaining knowledge and skills, with metacognitive aspects being a lower priority. The Economist recently published an article citing the work of the Education Endowment Foundation who demonstrated that metacognitive strategies are the second most cost effective intervention in education (Economist, 2016). Toon qualifies his comments by saying the knowledge and skills are a vital part of phronesis, but the heart of professional education should be attention to nurturing professional virtues. This is where my priorities lie, thus embracing the broader meaning of Phronesis as used by Alasdair MacIntyre in his book *After Virtue* (MacIntyre, 1981) relating to professional practice, rather than just moral decision making (Aristotle's own approach on a narrower conception of 'practice').

The following table describes Aristotle's intellectual virtues. Whether this can be read as discrete attributes or as an increasingly complex continuum is not the focus of this paper. I would like to assert that to date medical education has focussed on Episteme (knowledge) and Techne (skills), rather ignoring Phronesis e.g GMC Good Medical Practice (GMP) domain 1 refers to knowledge, skills and performance, GMP underpins training curriculums and continuing professional development for all doctors in the UK, the RCGP GP training curriculum also used to refer to knowledge, skills and attitudes (originating from Blooms Taxonomy), again taking a reductionist approach, skirting the importance of Phronesis and the integration of wider metacognitive aspects in the work of the clinician.

Type of Intellectual Virtue	Attributes	Reflections on the application to medical practice
(1) Episteme (Scientific knowledge)	**General analytical, universal, invariable, context independent. Not necessarily leading to any action.** ***Sophia (Pure theoretical knowledge*)** is achieved through understanding first principles (nous)/universal truths.	Seems to fit best with the scholarly research that generates rules and guidelines adopted in EBM and SBM (Reeve 2010).
(2) Techne (skill)	Making and doing things (Craftsmanship/Art) Techne resembles episteme in implying knowledge of principles, but differs in that its aim is making or doing. **Pragmatic, variable, context-dependent. Concerned with production.**	Benefit will result from the doing, but the level of understanding really doesn't extend beyond the mechanics of the Interaction. Mastering the *Art of medicine* is a common aspiration that blends the scientific universal knowns with the context specific matter. It falls risk of limiting things to problem solving? For a surgeon this has a different *craftsmanship* meaning too.
(3) Phronesis (Practical Wisdom)	Critical integration and interpretation of knowledges, leading to deliberation about impact of action. Requires rational thinking where values conflict, and capability to act. An ability to discern how or why to act virtuously encouraging virtue and excellence of character in others. It relates to Ethics and the right end goal. **Pragmatic, flexible, context dependent. Requires political (communities), nous and thinking abilities.** **Oriented toward action.**	Phronesis is imperative in delivering interpretive medicine (Reeve 2010). It captures HOW rather than WHAT knowledge is used. Probably a more useful intelligence for today's knowledge-overloaded clinicians. Draws upon not only factual knowledge but the moral character and reflective abilities of the clinician, synthesised into an action whose reach is beyond the matter at hand.

Fig 1 – Ways of Knowing (Aristotle – Nichomachean Ethics). Adapted from online text by (Pedemonte, 2014)

Kinghorn (Kinghorn, 2010) also suggests that phronesis rather than techne (practical skill) must be the guiding logic of medical professionalism educational initiatives (concurring with MacIntyre's approach to a phronesis approach to professional practice) .

Toon takes a MacIntyrean interpretation of Phronesis (focus on professional practice in a broad sense) which is slightly different from the Aristotelian definition (focus on moral practices). Kristjánsson describes this difference well, but I feel delving into this now is beyond the scope of this paper (Kristjánsson, 2015). My preference is to take the broader MacIntyrean definition of Phronesis which relates to holistic professional practice. I don't think Phronesis can be developed in isolation of other professional virtues (e.g. compassion, integrity), and to describe it as a *moral practice* may confine it to the domain of abscondable medical ethics lectures, when it has the potential to positively infuse wider professional practice.
Gillies distils the ethical problem categories for GPs into clinical decision making and resource allocation (Gillies. J, 2002) . Gillies feels that Aristotle's practical reasoning approach can integrate EBM, narrative based medicine and complexity science, appreciating the indefiniteness and indeterminacy whilst maintaining situational appreciation (p 518). Miller (Miller, 2015) reflects in an article on 'myth-based medicine', that EBM was meant to deliver us from foolishness. He writes that EBM has failed to lead us to true objectivity because intrinsic to the job is the need to make moral judgements. The expertise that the EBM promoters acknowledge is necessary, is based on intuition and instinct. A little known fact is that NICE (the National Institute of Clinical Excellence) also have the caveat that the clinical guidelines *are not mandatory and the guidelines do not override the responsibility of the clinician to make decisions appropriate to the circumstances of the individual patient.*

Cultivating a tolerance for uncertainty and having curricula to support that is echoed in a paper on 'Tolerating uncertainty- the next medical revolution', calling out to all fields of medicine, not just the generalists (Simpkin and Schwartzstein, 2016).
Dr Roger Neighbour sums up nicely, *"In complex situations, what is needed is phronesis, not check-lists. In phronesis rational intellect co-operates with the resonating, intuitive inner physician, worldly-wise and self-aware, so that the 'best under the circumstances' response that emerges is based on all the information available, including that which is discovered when the doctor swivels the gaze inwards".* The Inner physician p295 (Neighbour, 2016)

Miller (2015) and Neighbour (2016) both concur that the work of the GP is largely about choosing *which* medical narratives and patterns to espouse. Neighbour (2015) audaciously amends Miller's pyramid for generalist use (p 286) where he places "deciding whether" above "doing" at the top of Miller's pyramid. This sentiment echoes work by Ericsson, Charness, Feltovich and Hoffman (Ericsson, 2006) on Expertise and Expert performance. I think it embodies the real meaning of wisdom.

Neighbour (2016) completes his trilogy of books, written over 12 year, with "The Inner Physician" where he also declares 'Phronesis' as the hallmark of the modern generalist (chapter 11). On introducing Phronesis, Neighbour writes; *"When a well-informed intellect is complemented by well-developed self-awareness, the understanding that results can be helpful beyond recognition" (p 285).* So we have respected GP academics Neighbour, Toon, Gillies, Misslebrook and Reeve leading us to gatepost where Phronesis in Medical Practice (specifically Family Medicine), should be explored and researched further, not only as a marker of quality but as a focus of medical education. Phronesis seems to lend itself well to the work of the General Practitioner.

Kristjánsson takes the Aristotelian definition of Phronesis when he explains that Phronesis is a virtue of thought which adjudicates the moral virtues leading to action or reaction in the field of moral decision making (Kristjánsson, 2014a). As clinicians we often find that moral virtues compete, and we have to make a decision based on the right end-goal.
Clinicans' are moral decision makers. Aristotle claims that moral virtues can be developed by habit, Phronesis re-evaluates and critically appraises with Eudaimonia (individual and societal flourishing) in mind. Deprived of the right end-goal, the mode of thinking is just cleverness, or with the wrong goal in mind or with under-developed moral virtues, the result may be described as cunning or manipulative.
There are other intellectual virtues which all aim at human excellence (arête) but have a different emphasis and driving forces.

Virtue Ethics as an enhancement (or antidote) to Code based ethics

Returning to the positivist methodology that dominates medical education and the societal need for rules, evidence and guidelines as means to regulate, measure and standardise care provision. This

manifests as favoured ethical frameworks which can be classed as code-based (or rules-based) ethics.

The formation of the NHS in 1948 represents an essentially Utilitarian-Consequentialist model of healthcare free at the point of access. Its aim was improving the health of the Nation (the single currency outcome). Utilitarianism being introduced by Jeremy Bentham (1748-1832) and Stuart Mill (1806-1873).

With UK healthcare commissioning and provision of services following a free-market commercial path, as in the USA, an element of Libertarian philosophy prevails (first described in 1789 by William Belsham). Libertarians believe in the right of self-ownership in a free, unfettered, commercial market (Sandel, 2009). This model is intolerant in easing inequality and promoting common good. To me this model reflects society's fixation with hedonic (as opposed to eudaimonic) outcomes.

The other overriding moral philosophy in medical education is Deontology. An ideology heavily influenced by the work of Immanuel Kant (1742-1704). Deontological reasoning has no concern for consequences, just for duty (Dale, 2013). Kant discusses in his 'Groundwork' that morality is not about maximising happiness, or any other end. It is about respecting persons as ends in themselves (Sandel 2009). Deontology forms the basis of the present day Universal Human Rights declaration (1949) and the GMC 'Duties of a Doctor' document (GMC, 2013). Also under the Deontology moral framework is the four principle ethical model from Beauchamp and Childress (1979), drilled into medical students who are often oblivious to alternative moral underpinnings.

Beauchamp and Childress (1979)
Autonomy
Beneficence
Non-Maleficence
Justice

Dale calls upon clinicians "to become more aware of the frameworks which shape decision making, having awareness of their "ethical shadow" (Dale, 2013).

Deontology and Consequentialism have been favoured due to their apparent impartiality (Dale 2013), but they are both rules based, outside-in models and rules fail as they are inflexible (Schwartz. B and Sharpe. K, 2010)

Jost and Wuerth present a compelling argument in their introduction to their book on perfecting virtue (Jost and Wuerth, 2010). They speak about how code ethics has focussed on actions and

"rightness" at the expense of developing character and virtue. The code based (Kantian) approach has led to an over emphasis on rationality, a failure to recognise the moral significance of emotion, impartiality revered, failure to recognise the importance of relationships, community and loyalties along with an over-emphasis on an individual being the focus or moral concern.

Gardiner feels that virtue ethics is well suited to the medical consultation (Gardiner, 2003). It recognises the clinician's emotions are an integral part of their moral perception. It considers the motivation of the clinician rooted in their characteristic virtuous disposition. There are no rigid rules to be obeyed. It can be specific, with two people resolving the same situation in different 'good' ways, this flexibility encourages creative solutions. Virtue ethics accounts for the fact resolution of a dilemma may not be to the complete satisfaction of all parties and residual emotions may remain, but the integrity lies in the fact that the best decision has been sought.

Research trends

Areas of empirical weakness

Kristjánsson (Kristjánsson, 2014b) writes that literature on the actual cultivation of phronesis is sparse. In his appraisal on the literature to date, he suggests that there is little in the way of detail regarding conducting Phronesis education (p3). Most previous literature can be found under the remit of developing professionalism.

Hutson and Myers write from a surgical perspective (Hutson and Myers, 1999), like many others they propose Phronesis as the real work of a doctor, acknowledging the individualised prudent, careful decision-making required. They describe Phronesis as "an open window through which to see clearly how to act for the sake of patient well-being". The paper does not go on to detail how we can develop phronesis.

Hilton and Slotnick write in terms of emergent professional development (Hilton and Slotnick, 2005), and see Phronesis as a defining characteristic of professionalism attainment. They introduce the importance of medical education curricula that develop meta-skills along with an appreciation of the organisational and environmental conditions in which clinicians learn, acknowledging the powerful effect of the hidden curriculum. Their paper does begin to suggest how Phronesis can be developed and introduce developmental areas: psychosocial, moral and reflective. They feel this is a longitudinal vision that spans the career of a medic. They conclude by stating it is beyond the scope

of their discussion to outline the content and assessment that should underpin the continuum, recognising that doing so will be a challenge.

Gillies (2005) details how practical reasoning and Phronesis is adopted within the GP consultation. This is useful and he outlines very specific way to educate on its application. On describing a modern account of practical reasoning Gillies allows for the *integration* of code-based ethics with virtue ethics, "Aristotle is not denying that general rules may be used in decision making. However, deliberation starts from a consideration of the particular" (p 14) also suggested by Yang (Yang, 2013) Gillies paper delivers a convincing description of practical reasoning in the GP setting, he outlines the components of situational appreciation (perception, evidence versus intuition, imagination - deliberative phantasia and emotions), needed for an effective GP consultation. Fish and De Cossart provide a similar schematic for the secondary care out-patient consultation (Fish and De Cossart, 2013). Gillies also puts this in context reflecting on how the GP General Medical Service contract had a bias against the encouragement of situational appreciation. Schwartz and Sharpe present Phronesis as an ideal against a back drop of rules, incentives and codes within an audit culture (Schwartz. B, 2010). More recently the Jubilee Centre for Character and Virtues, University of Birmingham has developed an e-learning package for professionals, this has come some way in bridging the gap but wider uptake is needed:

http://jubileecentre.ac.uk/1649/character-in-the-professions-medicine

The fact remains that there are family doctors out there who do a brilliant job. Their excellence is not solely related to being clever, knowledgeable, up to date, or intelligent. We know from looking at the nature of GMC complaints that the majority of unhappy patients escalate because they have not been treated kindly or with due care and deliberation. Using a virtue ethics framework to support the study of phronesis one hopes that this research will be a step towards capturing enacted phronesis in general practitioners.

Research questions

The research adopts mixed methodology using self- reported questionnaire, narrative one to one interviews and retrospective NHS appraisal portfolio analysis. It is hoped that using this combination of study will enable a more holistic assessment of what enacted phronesis really means. When looking at moral virtues we need to encompass the cognitive, affective and attitudinal aspects in terms of understanding, exhibition of wisdom related behaviours and motivation. I like the 'trilogy of the mind ' term ***conative*** as it incorporates endeavour, striving and motivation in connecting the

cognitive and the affective. This mapping has worked successfully when studying the moral virtue of gratitude (Morgan.B et al., 2017).

There are inherent difficulties in observing live clinical interactions (practical, ethical) which is a method I have chosen not to use. Looking at electronic portfolios will enable information to be gathered from other sources (MSF data from colleagues and PSQ data from patients). The portfolio also gives me insight into the doctor's openness and capacity for reflection. Complaints and compliments along with significant event analysis are also usually included in the appraisal portfolio. I recently heard a quote I found most profound, "The process of investigating changes what you find". I would need to be reflexive when considering my personal effect on the enacted wisdom of others.

The table below maps each research question to the research methods providing an overview of how triangulation might be achieved.

1. Ardelt's 3D Wisdom inventory (n@200+) - Self reporting scale
2. Narrative Interviews (n@20) – Storytelling life view
3. Portfolio analysis (n@20) – Retrospective look at their performance based multi-source portfolio of evidence with opportunity for reflection

The over-arching questions:	**A3DWS**	**NI**	**PA**
What does enacted Phronesis in a General Practitioner look like?			
What characteristics are common to GP Phronemii? How does the expression of these characteristics differ from GP peers?			
Is Phronesis in General practitioners a transient or stable state? Can Phronesis consistently be demonstrated?			
What do GP Phronemii do differently in relation to their approach to practice?			
Does enacted Phronesis result in better doctor-patient relationships?			
Does enacted Phronesis result in a sense of greater personal well-being?			
The sub-questions:			
Do higher wisdom scores on the Ardelt 3D wisdom scale relate to increasing experience/age of the practitioner?			
Is there a relationship between the sex of the doctor and their ability to demonstrate enacted Phronesis?			
Do wiser GPs work full time?			
Have wiser doctors worked in other specialities or other areas?			
Is a higher wisdom score correlated to higher job satisfaction?			
What motivates wise GPs?			
What are the life goals of wise GPs?			
What other virtues do the exemplars display?			

Is there evidence that GP Phronemii tend towards the 'Golden Mean'?			
Do the three methods of study concur?			
Contemplative questions:			
Can these results be replicated in other areas of medical and surgical practice?			
Would any strong themes be applicable to broader medical education or just GP education?			
Can a Phronesis approach to medical education improve patient outcomes and clinician job satisfaction? (towards eudaimonia)			
Can the Phronesis be taught as part of medical education? If so how?			
What research is required next?			

The research is currently at the stage of data collection for part 1 (Ardelt 3D Wisdom questionnaire). It is early days regarding predicting the impact of this research, but it is hoped that the research will (ironically) lead to some *generalisations* that might ensure that the dominant rules-based, positivist, target and curriculum driven approach has some empirically driven plausible contention. This may intellectually incentivise future work on its potential in medical education, aspiring to **eudaimonia** in the National Health Service!

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