



**Phronesis in Medical Practice:
The will and the skill needed to do the right thing**

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Introduction

Medicine is in a quandary. Despite remarkable, even dazzling advances in both diagnosis and treatment, there is a growing discontent with health care, both from patients and from clinicians themselves. There is a sense that medicine despite these amazing advances, has in some ways lost its grounding.¹ In Aristotelian terms one could argue that there has been a focus on the *techne*, or the technical knowledge and expertise of medicine, but we have failed to develop the *phronesis* or practical wisdom necessary to *do* medicine in the best way possible. Practitioners need practical wisdom to make tough, everyday decisions in messy situations where guidelines and checklists fall short.² Medicine is about the health of people, and human beings are not objects but choosers. Freedom and preferences are important. Medicine is about quality of life and not just quantity of life years. It is filled with ambiguity, with difficult choices between competing values, and with the complexity that comes with navigating the human mind, body and spirit.

We all need practical wisdom says Aristotle, because we are all choice making beings with the potential to discern both *what* the right thing is to do but also—often far more complicated—*how* to do it. The choices we must make often occur in ambiguous, complex, and contradictory circumstances where we rarely have complete information. Rules and incentives are of limited use in getting us to act rightly and can sometimes even undermine our will and skill to do so.^{2,3} So how do we make these choices, and what helps us to make wise choices in these complex circumstances? We have tended to compartmentalize various virtues in medicine. In this paper we seek to describe how practical wisdom is necessary for *every* aspect of doctoring, and further claim that practical wisdom is the *uber virtue* necessary for the application of all other virtues in the practice of medicine.

To that end, we sketch out some of the everyday decisions doctors make that require practical wisdom. We then articulate the character traits and moral skills that are constitutive of practical wisdom and why they are critical to medical practitioners who want to practice well. Our focus then turns to the question of how medical practitioners learn practical wisdom and how such learning can be nurtured. We argue that institutions

can be designed to foster the capacity for wise choices—just as they are currently organized to undermine and corrode this capacity.

1. Why Doctors need Practical Wisdom in their Everyday Practice.

The everyday choices made by medical practitioners involve figuring out what is **relevant**, deciding how to **balance** conflicting goods, and grappling with **how to** do the right thing. Such choices demand practical wisdom.^{4,5}

Relevance Problems. Medical practitioners are always making decisions about what is most **relevant** in a particular context: with *this particular* patient in *this particular* circumstances at *this particular* time. This of course involves the skill to determine the relevant clinical symptoms and signs to make a correct diagnosis, and what particular patient characteristics will make for a good plan. Is this back pain concerning for a malignancy in the spine, or is the cause more likely the ergonomic conditions of the work place? How much does the patient want to hear and how much does the patient need to hear? Is it information, compassion or tough love that is most relevant at this moment? Which of the patient's major complaints are her chief concern? Is that chief concern really the most urgent? If not, how does one explain that and ease the patient's anxiety?

Balancing Problems. Often more than one thing is relevant, and sometimes they are in conflict. Sometimes the right things to do must be balanced with the pressures created by the scarce resources, demands for profit, and bureaucratic rules of the institutions in which practitioners work. So medical practitioners are frequently **balancing** conflicting goods.

Balancing honesty, empathy, detachment: What kind of honesty is needed at this particular moment? Is it telling the patient the unvarnished truth or “telling it slant” in the words of Emily Dickenson.^{6,7} Similarly, doctors and nurses frequently need to balance detachment (to wield a scalpel, face tough clinical facts, and cause the suffering that many treatments demand) with empathy for the patient and the need for compassion. When Anthony Kronman talks about the importance of teaching young lawyers how to balance detachment and empathy when counseling clients he likens this to wearing “bifocals.”⁸ (See also the ‘bedsores’ case in Jerome Groopman’s book *How Doctors Think*).⁹

Balancing autonomy with beneficence: Practitioners need to balance what the patient wants to choose (patient autonomy) with what the medical professional thinks is best (beneficence—or paternalism). So a doctor often needs to understand what treatment choices are “preference sensitive” (for example for prostate cancer) and how to help counsel a patient in making this choice. She needs to figure out what to do when the patient wants to make the choice but does not really understand the situation or is hazy or upset, or otherwise unable to make choices. Balancing patient autonomy with beneficence is particularly tough because the very way a doctor frames the diagnosis and

treatment options, or presents the statistics and survival rates—even the very tone of voice and body language of the doctor—*always* nudges the patient to choose one way or another.

Balancing competing needs of patients: Good doctoring and nursing always demands good listening and good communication but it is very difficult to balance the time needed to do these things with the needs of other patients.

Balancing the needs of patient vs. needs of society: Medical practitioners often need to balance the needs of their individual patient with the needs of society in an environment of limited resources. In general, physicians are trained to care for the patient in front of them, and to advocate for appropriate care for that individual patient regardless of their ability to pay for that care, or that patient’s social or political views or alignments. This doctor patient relationship trumps **all** other concerns, including monetary, personal (to the physician), or social costs to that care. It is therefore difficult, and in many cases a direct challenge to their primary responsibility, for a physician caring for an individual patient, to choose on behalf of society (or self) when they are caring for an individual patient.

Balancing the needs of patient vs. needs of one’s self and one’s own family: Physicians who have families are often, in the modern day, struggling to balance ongoing commitment to their own families with the needs of their patients. Should I be a good doctor or a good parent? Do I care for myself (i.e. eat, sleep, show up for my family) or do I care continuously for my patients? This is perhaps one of the most agonizing challenges physicians face, highly personal and deeply wounding in many cases. Physicians are generally struggling with balancing values that, almost by definition, cannot be successfully navigated. If the “good doctor” narrative means being available, at a moment’s notice, and the patient’s needs trump all others, then there is an inherent and often fatal conflict.

How-to Problems. Even when medical practitioners know what the right thing is to do there are still tough choices about **how to do** these in the right way.

Balancing honesty and compassion demands knowing *how to* deliver bad news to *each* particular patient—what to say, how much to say, and how to say it.

Dealing with a patient whose racism, homophobia, sexism or religious intolerance is directed at the practitioner demands not only knowing whether and when to make an issue of this but *how to* talk with that patient and how to call in assistance.

In counseling a patient, a practitioner needs to know *how to* frame the options and the likely outcomes. Do I use statistics—and which ones, mention the survival rates first or lead with the death rates; downplay statistics and talk about what can be done now, figure out what the patient is ready to hear and when.

In noticing a medical error, for example, the choice remains *how best to respond*: when and *how* to report it, how to talk with the family or patient, and even more broadly how to set up a system or program for quality improvement or for helping doctors deal with mistakes they have made.¹⁰

Why Such Choices Demand Practical Wisdom. This brief list of relevance problems, balancing problems and know-how problems illustrates some of the everyday moral choices that medical practitioners must grapple with to do their work well, to achieve the aim(s) of medicine: do no harm, promote health, alleviate suffering, give the best care possible for people to live healthy and happy lives. Rules, standard procedures, best practices and checklists are critical scaffolds for such choice making but they are not enough. That is because the kinds of choices we have mentioned all share certain characteristics that befuddle such standard decision making tools and that demand practical wisdom.

(a) these were choices “characterized by multiple correct solutions, each with liabilities as well as assets” and there were “multiple methods for picking a problem solution”¹¹

(b) the choices were context dependent and there was no clear rule, procedure or best practice guideline for that context.

(c) the choices were “unformulated or need reformulation.”¹¹

Unlike textbook problems these choices did not come pre-packaged so the doctor or nurse counseling the patient needed to figure out how to frame the diagnosis, the treatment options and the likely outcomes.

(d) The evidence was incomplete or ambiguous but was the best that could be had at the moment the choice needed to be made.

(e) The choices were ‘preference sensitive’, the outcome was uncertain and the patient needed to figure out what risks to incur.

(f) Even when the medical practitioner knew *what* the right thing to do was it was truly difficult to know *how* to do it.

In such circumstances it is *phronesis* that enables medical practitioners to discern what is the right thing to do and equips them with the skills to do that right thing, even in very difficult circumstances. What does practical wisdom require? Medical practitioners need (a) certain character traits which dispose them to act rightly; (b) they need skills in awareness and self-regulation/self mastery which enable them to be fully aware of the complexity of the situation, and capable of a full range of responses; (c) they need basic moral skills which enable them to discern; (d) they need regular practice in these skills throughout their educational lives and (e) they need a practice environment in which these skills can be reflected on and honed in the context of adversity, difficult and

complex human experiences—a *wisdom matrix* in which *phronesis* is practiced and gained, to be applied to the next difficult circumstance.

2. The Crucial Character Traits Wisdom Demands

A clinician cannot make these tough decisions without certain mentored character traits. Such good character is at the heart of the dispositions and habits which dispose or motivate practitioners to do the right thing. Aristotle argues such virtues are learned habits or dispositions (*hexis*) and the affective and the cognitive—not terms he uses—are fused and interwoven in being a practitioner of a certain kind. We need to know what compassion and courage are, for example—to recognize them, to know they are important and why. But we also need to have the dispositions, the internal compass, which makes us intend to actually act in these ways. A short list of the virtues essential for good medical practice might include the importance of being compassionate, courageous, empathic, detached, honest and fair. A longer list would include being resilient (having fortitude), humble, mindful, curious, self-effacing (disposed to place the patients interests over the doctor’s self-interest), to be faithful to the trust a patient puts in a doctor, to have the desire to continuously learn and inquire and improve, a willingness to accept responsibility for one’s actions, an openness to criticism and feedback, to be open-mindedness (as in a disposition to suspend immediate judgment), to have a disposition to collaborate with and learn from others.¹²

Many experienced practitioners might not even ask why these character traits are essential to the practice of medicine because they are so embedded in the very nature of the practice. To say that so and so lacks compassion, is a coward, is unempathic, is not disposed to be detached and is unreflective and to also say that this person is a good doctor, or even a doctor, would seem strange to many both within and outside of the profession. Why? Medicine is not just a set of technical skills, it is also a use of the therapeutic self; it is a practice with the aim of service to patients, and that *telos* includes restoring to health, reducing suffering and harm. These traits are not simply nice “add ons” that a doctor might also have; they are essential to the practice. Yet there is growing concern that these traits are being under-valued and even corroded in medical schools and practices. Medical schools, concerned about this erosion have, for example, underlined the importance of such traits by naming specific “competencies” they want to nurture in doctors (for example professionalism, communication, empathy, compassion, respect, subordination of one’s own self interest, etc.) in an effort to make clear that these are an essential part of being a competent physician.¹³ Is it possible for a “good doctor” to be a good technician (i.e. remove a mole competently) but be unable to have a compassionate conversation with the patient when the pathology reveals melanoma?

3. The Moral Skills Practical Wisdom Demands: What Are These Uber Capacities?

Such dispositions or virtues alone, however, are not sufficient for good doctoring. To exercise these traits or habits, doctors need to gain the *capacity* (some might say the *competency*) to actually act. It takes a certain *know how*. A doctor without practical wisdom will generally lack the capacity to know how to *be* compassionate, empathic, detached, courageous, mindful, and reflective, and will be unable to balance different “goods” when they inevitably come into conflict. Empathy, for example, demands good listening skills, as well as the capacity to engage those skills even when exhausted and stressed. Compassion demands more than the desire to alleviate a patient’s suffering; it demands the capacity for empathy (understanding how the patient is thinking and feeling), and the capacity to engage that empathy even in situations where the patient is belligerent, angry, or violent toward the doctor; it demands the know-how to figure out what the patient wants and to balance that with what the patient needs and what the medical possibilities are. Without such moral skills compassion deteriorates into feel-good incompetence. Similarly courage demands more than fearlessness or the willingness to act in the face of fear: it demands the technical skills of diagnosis and treatment, knowing how and when to take risk, and the emotional self-mastery to control both anger and fear; otherwise would-be courage degenerates into foolhardiness.

The ethical (and technical) capacity to translate these character traits into the appropriate actions for *this* particular patient at *this* particular moment demands both *judgment* and *self mastery*. The judgment and the self-mastery to act wisely is what theorists since Aristotle called *practical wisdom*. It is the *will and the capacity to do the right thing in the right way at the right time*. None of the character traits so essential for being a good doctor can be translated into action without such judgment and self mastery, or practical wisdom. Absent practical wisdom these traits may indicate good intentions, good motives, good desires, good emotions. But to truly have the character traits or habits of a good doctor physicians need the master virtue, practical wisdom.

It is important to note that there is a reciprocal relationship here: you can’t have good character without practical wisdom, but you also can’t have practical wisdom without good character. Practical wisdom is not simply a skill or technique that can be learned. Its not simply learning how to reason, how to analyze, how to do a logical deduction, how to surgically repair a broken appendix or sew a suture. A doctor can only have practical wisdom if she has learned the character traits that motivate her to do the right thing—and she can only do the right thing if she can exercise this kind of practical judgment, will and skill. Aristotle emphasized that no one can have the moral virtues without *phronesis* and anyone with *phronesis* has the moral virtues:

“It is plain, then, after what has been said, that it is not possible without practical wisdom to be really good morally, nor without moral excellence to be practically wise”¹⁴

Linda Zagzebski writes in *Virtues of the Mind* that “the very concept of moral virtue refers to the person with *Phronesis*.”¹⁴

A preliminary list of the somewhat overlapping and closely related skills or capacities that constitute practical wisdom would include the following:

1. *Noticing Skills (awareness)*. These are abilities to perceive a context and discern what is morally relevant in that particular circumstance, as well as the ability to be aware of one's own biases and vulnerabilities. Among the important skills here would be (a) the capacity for mindfulness, to be in the present and see what is around you; (b) the ability to suspend judgment; (c) the ability to recognize and control social bias and thereby expand the choice of response once the bias has been brought to consciousness.¹⁵

2. *Perspective taking skills* : the ability to see things from different angles, the ability to recognize and question assumptions, to put yourself in the heart and mind of various participants. Such skills are essential for the empathy at the heart of good doctoring.

3. *Good listening and relational skills*. These skills are essential for noticing what is relevant in a particular medical situation, to hear and see and feel things that a patient herself might not have noticed and to make sure that a patient really understands enough of the diagnosis and treatment that she can make good health choices. The difficulties young practitioners have in basics like learning how to take a patient history are illustrative of the importance—and difficulty—of learning these skills.¹⁷ Such skills include not only the ability to understand what is said but to notice emotional expression, to read body language more generally and to hear and interpret patient narratives and stories. The fundamental medical virtues of empathy and compassion depend on the know-how to listen.^{7,18}

4. *Imagination* is the critical faculty of bringing to mind things that are not yet present to the senses. It is critical for a medical practitioner to imagine, for example, the consequences of a treatment choice (or a choice not to treat) for a patient and her family and for the practitioner herself, and to help those involved imagine this too. Wise choices for all parties depend on this capacity and the skills at communicating it.

5. *Capacity for Improvisation*. Improvisation is the capacity to combine old skills and knowledge in new ways to deal with the unexpected. Improvisation is the capacity to make things up quickly, on the spot, out of past experience and out of the current circumstance. The creativity of improvisation usually emerges from some structure: e.g. cooking without a recipe based on what is in the fridge plus past experiences cooking. When one standard medical explanation provided to a patient does not work, the practitioner needs to be able to improvise another that will. When a procedure does not go as planned, skill at improvising—and working with others to improvise—becomes critical. Improvisation works with *imagination*: the capacity for creativity, imagination, improvisation are what enable someone to respond wisely in unplanned and unrehearsed situation

6. *Balancing skills*: The capacity (skill) to balance clashing principles or aims or values, or to choose between better or worse. Such balancing depends on the particular patient

and context and demands imagining the choice that will achieve the right balance in this situation. Among the major balancing acts that doctors are always learning how to do are balancing empathy with detachment, balancing beneficence with patient autonomy, balancing when to ask with when to tell (particularly important for med school teachers with their students but also doctors with their patients), balancing patient health and public health. A wise doctor, one with practical wisdom, has the capacity to balance such conflicting goods.

7. *Deliberative skills*, the capacity to reason about the goodness of the consequences of a choice. This involves the ability to determine what the aim or purpose of the encounter is—there may be many things at stake but what are the most relevant? What are the clashing aims or values that must be balanced? What courses of action are actually possible (not simply ideal)? This is something palliative care doctors, for example, need to do all the time. And what does our technical skill and experience tell us about the consequences we imagine our choices will have? We also need deliberative skills to figure out which path will be best given the aims of medicine and the aims of the patient. Note that perception, imagination, improvisation and balancing are all necessary skills for such moral deliberation.

8. *The capacity for reflection and mindfulness*. These are the skills needed to learn from past or current experiences. This includes self-reflection, the capacity to rise above one's own perspective and to see things from many points of view, the capacity for non-judgmental moment-to-moment awareness, and the capacity to notice but not be driven by emotion when making decisions and acting. Such reflection can be done alone but is enhanced through reflection with others which in turn demands the right environment or "wisdom matrix".

9. *The capacity to determine the relevance of a particular issue*, its deeper meaning in light of the purpose of medical practice and of a particular encounter. This is the capacity to discern what the main thing is and focus on it—in Stephen Covey's words, "The main thing is to keep the main thing the main thing."¹⁹ Another good example of this discernment can be found in Blaine Fower's description of an intervention by family therapist Charles Fishman.²⁰

10. The capacity to tolerate ambiguity and complexity, making it less likely that someone will inappropriately simplify a complex problem.

11. The ability to recognize assumptions and frames, to see their importance in shaping the medical choices of doctors and patients, and to use them appropriately.

12. Self-regulation/self-mastery: Nothing done with a patient can come out of the physician's needs. The relationship with a patient is a therapeutic relationship. Every interaction between physician and patient is intended to be therapeutic. The words, gestures, touch, all measured in the same way one measures out pills...right drug, right dose, right time. In order to do this well, the physician has to be self-aware, and have the capacity to manage his/her own emotions and actions. ().

4. What's Up With the Tattoo? An Illustrative Case

If medical choice making demands practitioners with practical wisdom—with the character traits and moral skills we have been discussing—how might that look in practice? In our research we have been asking physicians to talk about experiences that they felt would illustrate practical wisdom. Dr. S tells us this story.

JT had been beaten most of his life. He was a patient a homeless shelter. Mean. Tough. The first day I saw him, he looks at my name. (Dr. S, a typical Jewish last name)...that's your name? He rolls up his sleeve. There is a huge swastika tattoo and it's dripping with blood. I said: "what's up with the tattoo?" He said: "Well...I think you know." I just by passed the remark and went on with the medical exam. [Dr. S commented to those of use in the group hearing this story that seven of his grandmother's children were killed in the German camps]. "This patient came in many times.....and his sleeve was rolled up....and after many visits, I noticed that his sleeve was not rolled up....and he sent his children to me. Fast forward 11 years later. His last visit. I looked at JT's arm and it was all inflamed where the tattoo had been. I said: "TJ: you have dermatitis on your arm and it looks terrible." I asked him: "what's up?" He bit his lip again. He says: "since I met you I have been trying to rub it off...."

I don't know if I did anything for his health....But it was about the most meaningful thing that happened in my professional life. Its calling to us to be in the moment, to be our best selves in terms of the other....".

Dr. S himself did not underline the choices he was making when he told his story but as our group listened and imagined ourselves in a circumstance the complexity of the choices became clear. We'll outline some of them here so we can see the kinds of character traits and fundamental capacities (or moral skills) that Dr. S needed to make these choices. Because these traits and moral skills are necessarily interwoven we will signal the **character traits** in **bold** type and the *fundamental skills* using *italics*.

At the start of the exam Dr. S first had to *notice* that he had a situation of moral conflict, and to *notice* that he had a number of choices in how to respond. He could have ignored the outthrust swastika and started the exam. He could have challenged JT's anti-Semitism. He could have told JT that he found his tattoo and comment threatening. He could have told the JT what feelings this evoked, given what happened to his family in Nazi Germany and used that to critique the patient's anti-Semitism and make a point about justice and bias. He could have said "oh, that's a well-done tattoo" and gone on with the examination.

He chose to neither ignore nor confront, but to turn the out-thrust swastika into a question: "what does that mean?" Here too he had choices, like his tone of voice. The

tone he repeated to us was open and inquisitive and non-confrontational. He could have said the same words with a very different meaning. And when the patient responded “you know what it means...your name is S, isn’t it”, Dr. S had to make another choice: to engage or to ignore. He chose to simply continue with the exam and work on the health issue the patient had come in with. That patient, of course, had choices too: he could have walked away, or escalated the confrontation, but did not.

Buried in these visible choices are multiple underlying, more subtle choices. For example, Dr. S needed to decide whether the tattoo was a central issue in this patient interaction—was it *relevant* to diagnosing and treating this patient’s presenting problem? Was it *relevant* to developing a therapeutic relationship with this person? Was it *relevant* to helping this patient to achieve well-being? In solving the *relevance* problem, he had to know and embrace the *purpose* of his activity at that moment: he was a doctor. He was not a teacher with a group of 10 year old school kids being confronted with this person flaunting a swastika tattoo in a public place. Dr. S’s purpose as a doctor was to deliver knowledgeable, skilled, compassionate patient centered care.

Dr. S also had to make a quick *judgment* about the kind of threat this was. He had *perceived*—probably intuitively and not consciously—that this patient was being threatening but was not a threat. Such *perception* was rooted in Dr. S’s ability to *discern the context*. Where was he? He was in a homeless shelter with indigent poor people, with a variety of problems, psychological, social, and medical. And here was this particular person: how much of a threat did he actually pose? And what did the patient need from him at that moment—which may have been different than what the patient intended when he confronted Dr. S with the tattoo.

In order to actually make these choices, S needed awareness, and then the capacity to discern quickly and accurately whether this situation could be handled with a rapid-fire decision-making process or needed slower more deliberative decision-making. This points out the role of *reflection* in choice-making and the relationship between *reason, emotion, and intuition*. In the few seconds that Dr. S had to react there was little time for conscious, deliberative reflection. He could not have laid out four options, weighed the pros and cons of each one and picked the best—the standard model of decision making critiqued by Gary Klein in his books about naturalistic decision making and intuition.²¹ Daniel Kahneman would have described this as “system 1” decision making.²² Reflection was crucial for Dr. S. after the fact when he had time to reflect about what he did and what else he could have done, a “reflective practitioner” in a post-game analysis.²³ One lesson here for teaching is to help young medical practitioners recognize the myriad of moral choices they are making in even the most ordinary patient encounters. These are not like the case studies in an academic ethics class where a teacher lays out 4 choices and ask students to deliberate about the best. This is about first uncovering what the choices are, framing them as choices, and then allowing for deliberative reflection. Coaching students how to do this is a critical step in encouraging them to learn practical wisdom.

This fast, intuitive way of choice-making raises other issues (from the perspective of how practical wisdom is learned). Intuitions are not inborn. They are learned. Intuitions can be educated. This was Aristotle's insight in the *Nicomachean Ethics* when he emphasized the importance of developing the right habits before practical wisdom is possible.

We don't know how Dr. S. learned the habits and intuitions that allowed him to react that quickly. But we suspect that Dr. S. had some of the skills and habits of *mindfulness* long before mindfulness training became recognized as a legitimate part of medical training—the habit of being fully present and of taking a quick pause, a quick moment to assess, to get one's bearings.

In order to make these choices, Dr. S. needed both *awareness and mastery* over his own emotions, thoughts and actions. Dr. S.'s did not react immediately with anger or defensiveness. Dr. S. had to first *notice* what emotions were triggered by this encounter, and then had to have the capacity to *discern* when, how and for what purpose to express those emotions—a classic example, for Aristotle, of the exercise of practical wisdom. Dr. S. can not remember exactly his emotions at the time but speculating for a moment is useful for thinking about the possible relationships between emotion, reason and intuitions or habits.

One possibility is that Dr. S. felt anger and pain and was quickly able to overcome it, to *see (perceive, reason)* that anger was not relevant in this case and indeed could be damaging in this case—that this case was about relieving the patient's suffering and not about making a statement about bias, anti-Semitism, or justice. Another possibility is that Dr. S. did not feel anger or hurt because of the way he *perceived* the situation (TJ is suffering) and because of his deep **compassion** (I am here to help relieve that suffering). Another possibility is that Dr. S.'s habit of **wonderment** and **curiosity** and **problem solving** kicked in: what drove TJ to get this tattoo and why is he saying this to me now?

These and other possibilities underline a very important relationship between reason (cognition) and emotion (affect) and *reflection*: because of what he saw or *perceived* (or because of how he *framed* the situation), Dr. S. *felt* differently. The relationship certainly works in the opposite direction too. What we feel often *frames* what we see and think. Reason and emotion and reflection all work together, and with the right habits or intuitions they can allies which keep a practitioner focused on the right aims. Thinking about the learned synergy between the affective, cognitive and reflective elements of wisdom (Monika Ardelt's 3-Dimensional Wisdom model) has implications for structuring a wisdom-learning atmosphere: learners need to have experiences that educate emotion (affect), cognition (reason) and reflection, and they need practice in how to link these elements together.²⁴ Part of our "theory" is that, over time, such integrative practices can help people to see things differently, such that wise action actually gets easier to both discern and to implement.

Empathy and **compassion** were clearly at the heart of this story. Dr. S. needed some sense of what the patient was thinking and feeling: that he was belligerent and

angry, that he did not like Jews, that he was suffering and needed help, that the patient had made a decision to see Dr. Hirsh even knowing his name was S. and that he was Jewish. The impulse and the ability to understand and maybe even feel what was in the heart and mind of this patient—even if he were scared or repulsed by it—was foundational for Dr. S.. Thus his opening question: “what’s up with the tattoo?”

To be empathic, Dr. S. needed the uber capacities—the moral skills—to be a *good listener*. To do the *perspective taking* that empathy demands he needed to read the body language, hear the tone of the words, and to listen carefully to what was medically wrong with this patient. He needed to be **open** to hearing what was on the patient’s mind (and in the patient’s heart) which meant that he had to have the capacity to **suspend judgment** at least for the moment.

Good listening, of course, is not enough for a doctor unless the doctor is also a *good communicator*. Dr. S. needed to **know when and how** to use his own body language and verbal language to elicit what the patient had to say. The capacity to listen and communicate enabled Dr. S. to accomplish the purpose delivering a certain kind of care.

Dr. S. also needed the *capacity to tolerate ambiguity and complexity* and to live (at least for a while) with uncertainty (what did this guy mean? How serious of an issue was this going to be? Can I go ahead with treatment even though I do not quite understand what is happening here?).

Developing habits of **compassion** are an important part of encouraging practitioners to develop practical wisdom but medical education must also include fostering the motivation to act in the absence of compassion. For example, a good doctor might have acted rightly in this situation **without compassion** if that doctor were motivated by duty or principle. Imagine now a doctor who felt baffled, angry, mad, or hurt by the flaunted swastika; or a doc who intensely disliked this patient; or a doc who could not fathom how someone could think or feel the way this patient did. This doctor might still be able to press on to treat this patient because of the habit of duty or his commitment to the Hippocratic oath or a larger faith or some other larger purpose. This doctor-without-compassion might have given good care. To an outside observer, the care might have met the criteria of compassionate care—and all this in spite of the fact that the intention or motivation to **be** compassionate was not there. A compassion-inducing environment in medical education must also be an environment in which doctors have the habits and skills to act rightly in the absence of compassion because there will always be situations where feelings of compassion can not be counted upon. Such an educational environment would also involve “practice” and modeling in acting rightly even if you don’t feel compassion.

It is also possible that learning to act, to have the right habits without the right emotion, may eventually engender the right emotion. “Fake it till you make it”. If students learn to go through the proper motions, based on a very strong sense of duty or professional code, in spite of not really “feeling it”, then over time this young practitioner

may begin to “see” or feel in a different way. It could be thought of as a process of growing into the deeper compassion that derives out of positive relational experiences. In the wisdom study Plews-Ogan carried out, this learning process was described by both patients and physicians.²⁵ This study also found that “what helped” physicians deal with very challenging circumstances was “a moral context” or a “professional code” that helped them to go through the right motions, even when they weren’t feeling it—because they were so scared, or angry, or whatever.²⁶ These “motions” led to good, healing responses from colleagues, patients or families, and so the cycle got off on the right foot.

Dr. S.’s story underlines another character trait that all doctors need in far less threatening circumstances: the willingness to take risks and fail and try again. Such resilience and **courage** is not so much the overcoming of fear but the willingness to act in the face of it. JT flaunted his swastika tattoo to be provocative, even threatening. But courage, like the other character traits (or virtues) of empathy or compassion or patience is not just an affect or a disposition—a willingness to confront fear and risk. Courage also demands the uber capacities of practical wisdom to assess the situation and to decide whether to fight or flee or ignore or act calm. Dr. S.’s courage demanded the capacity to *perceive* the situation to get it right, to listen to what TJ was saying with his tone of voice and body. Courage demanded the capacity to *imagine* the possible scenarios that could have developed with this person in this shelter at that moment—and thus rule out any immediate danger. Dr. S needed the capacity to *assess the relevance* of what he saw: that the patient was, in fact suffering; that the threatening words were not, in fact, an immediate threat in these circumstances. Dr. S.’s fearlessness could have led to recklessness instead of courage had he not had practical wisdom.

In deciding how to treat this patient, Dr. S needed to *balance* good things that were in conflict. There was no simple rule or principle or best practice that told him how to rank order, prioritize or balance. Standing up against bias and injustice is a good thing—something we expect good doctors to do. Being honest with patients is a good thing. Diagnosing and treating them to relieve pain and suffering is a good thing to do. Protecting one’s integrity is a good thing to do. Preserving one’s health and safety so that you can continue doctoring is a good thing to do. In making the choice about whether and now to respond, Dr. S. was weighing these things and finding the right *balance* for this patient, and for himself, in this context. This *capacity to balance and weigh* frequently underlies the everyday choices doctors make: this capacity is one of the markers of practical wisdom in a doctor.

5. Designing for Wisdom

If therefore “wisdom is what we should be striving for in our development as clinicians...seeking wisdom should be embedded in our culture”²⁷ then practitioners and educators must think about how such wisdom is learned and how that learning can be fostered. We are avoiding framing the question as “how can practical wisdom be taught”—in spite of our continual efforts to teach it! Practical wisdom can’t be taught in any simple way. Nor can good character. Or good purpose. Courses in practical wisdom—like any standard ethics course—are at best insufficient. However, we do

believe that the capacities to develop wisdom through experience can be fostered in the educational process, and then the experiences which can lead to wisdom development can be provided and intentionally mentored throughout medical training. Capacities that can be fostered include compassion, reflective practice (through mindfulness, reflective writing, narrative medicine), perspective taking, tolerance for ambiguity, discernment and balancing. Once these fundamental seeds have been sown, then mentored experiences have a framework in which to be integrated. Medical practitioners are crafts people as well as scientists, and learning the practical wisdom to practice this craft demands that wisdom-learning experience be built into the fabric of medical education. “See one, do one, teach one” is a mantra of medical education that often refers to the learning of technical skills but it is equally valid for the learning of moral skills. Experience—practice—tells you what works and what does not work and provides the possibility to learn to do it better. This is true of any practical skill—and ethics IS a practical skill.

But not any experience will do. Many of our daily practice experiences are organized around organizational rules and mandates or around a structure of external economic incentives designed to encourage behavioral modification and such experience can actually corrode or undermine our capacities for judgment and our dispositions to act rightly.

To learn from experience you have to **structure experience so that you can learn the right things from it**. You have to design courses and institutions (and organizations) that encourage people to practice in ways that will teach them the skills (competencies) and the motivations (habits, dispositions) of wise practice.

In recent years a rich and diverse array of courses and workshops have been developed aimed at encouraging the habits and skills needed for practical wisdom. Many medical students, for example, have been in elective courses or workshops or groups that actively promote the habits and skills of compassion, empathy, good listening, and good communication. More well known examples include Balint Groups, Schwartz Rounds, Rachel Naomi Remen’s The Healers Art, the empathy training program developed by the narrative medicine courses developed by Rita Charon and Helen Reiss as well as focused courses in art and music for medical students.²⁸⁻³⁰ Looking at the grants awarded by foundations such as the Schwartz Center for Compassionate Care and the Arnold P. Gold Foundation give a quick sense of the attention being paid to such research and course design.³¹⁻³³

Sometimes such practices are integrated into the courses that are the backbone of the medical curriculum. Many medical schools require students to take a course (variously called Patient-Doctor Relations or On Doctoring)—often for two to four years—in which students learn these habits and skills in small groups with a doctor preceptor or facilitator who is also training them in some of the hands on skills they need as doctors. An example of another model is the third year Pediatrics Clerkship at Dartmouth’s Geisel School of Medicine and a program called From the Other Side of the Stethoscope. Students “write a reflection on a challenging encounter with a family in which there was a question about the best way to offer compassionate care. Students

share their reflections with the other students, and with a group of parents with children who have special health-care needs, called "family faculty." The faculty discuss the reflections with the students. "There are these incredible discussions where students say, 'I tried to break the bad news this way, was that the right way?'" says Steven Chapman, as assistant professor of pediatrics at Geisel who is involved in the course."³⁴

Such courses are far more effective if they are part of a broader institutional environment which encourages such learning. This is particularly crucial today because most medical institutions are structured to eliminate or discourage such experiences and to corrode the learning of practical wisdom.^{3,35} Individual courses might help individual student doctors survive, check, and even resist the effects of such institutional deformations of medical practice by legitimating wise, compassionate practice and by providing some practice and experience in the necessary habits and skills. But the best practical experience is the right experience itself: not only the formal curriculum but the informal curriculum—what happens inside the classrooms and wards and clinics in doctor student and doctor patient interactions—and what happens in everyday work experiences among doctors, nurses, students, staff, and patients. Institutional re-design needs to aim at encouraging an institutional culture and practices which systemically aim at encouraging the learning of the character and moral skills of practical wisdom. The idea is to create a learning organization with good judgment and good character at its core, a kind of *wisdom matrix*.³⁶ Designing institutions to encourage the right kind of experience requires another kind of practical wisdom—the practical wisdom of institutional architects, of system designers, of what Aristotle called statesmen.

Design Elements: A Preliminary List. What are the design elements that are “wisdom inducing”—that encourage practitioners to learn the skills and the will/disposition and the *telos* that practical wisdom demands?

1. Creating a wisdom-learning environment demands active **coaching** and **mentoring**—just like the method of “see one, do one, teach one.”

Medical and nursing students, third year clerkships students, residents and fellows learn the ethical skills and dispositions the same way that they learn other aspect of the medical craft: by repeated practicing under the guidance of mentors and coaches Building that mentoring and coaching into the structures of medical schools and practices demands that mentors and coaches not only be allowed the time by their organizations to do this—that this be part of their work—but they themselves need to learn how to do this: to be coached and mentored on being coaches and mentors.³⁷

2. Similarly important is good ‘**modeling**’: **Align the “formal” and “informal” curriculum** to re-enforce the learning of practical wisdom.

Built into wisdom inducing practice is good modeling The solid literature on the role of the *informal curriculum* in medical schools provides ample evidence that students develop habits and character traits of ethical practice by observing closely what the

teachers and head nurses and residents and attendings actually do in practice—as much if not more than what they are told in class or by the value statements and pronouncements of the institution or even the verbal pronouncements of their teachers.³⁸

What is taught, valued and preached in the classroom needs to be lived and practiced by the attending physicians, residents, and nursing staff in the wards and clinics. Because medical education is “moral enculturation” the “medical school functions as a moral community. . . . [E]thics makes only a small contribution in the community, since the most important determinants of physicians’ identities lie within. . . . the hidden curriculum and the broader cultural milieu within which ethics teaching must function.”^{39,40}

3. Structure Practices to encourage the virtuous circle of experiential learning. One way to think about structuring experience to learn from is an experiential learning cycle something like this: Doing/practice → Reflection → Learning/Theory → Doing/Practicing again. Note that this is not a linear path but a circle—a kind of virtuous upward spiral, and the starting place of this learning cycle depends on the subject matter, the practice and people’s learning styles.

4. Trial and Error. Essential to this circle of experiential learning is practicing and making mistakes—and learning from them. The experience needs to be structured so that you can experiment. That demands trial and error. Learning to admit error, to notice it in others, and to talk about how to learn from it requires building an environment of trust and safety. A “gotcha environment” is not a learning environment. And that itself demands teachers, facilitators and administrators with the wisdom to do some tricky balancing acts. For one: the near constant emphasis on the evaluation of personnel is in tension with frank admission and discussion of errors—and thus learning and improvement. To name another: creating a safe space for learning through trial and error in a medical environment needs to be balanced with the safety of patients.

5. Reflective Practices. The actual learning from trial and error demands reflection. You can only learn through practice if you have the will and skill to be **reflective** about what you are doing. Understanding perception, cognition, emotion, learning how to “notice” as well as how to set aside thoughts and emotion, all of these make up the reflective practices that are engaged in learning from experience. The more nimble the student becomes in engaging these, the more “real time” the reflection can be.

6. Problem Based Learning, in classrooms and in actual practice can encourage the circle of learning above. Such learning often involves **scaffolding decision making** with procedures, rules and best practices but then **designing problems/cases for students to confront** which take them to the **limits** of what the rule or best practice tells them and have them learn on the frontiers of ambiguity, complexity, and uncertainty. The Harvard Pathways program is structured around this method: give students rules which will fail; that gives guidelines and puts them up against experiences where rules and best practices are not working; and it’s at that point where the learning takes place.⁴¹

7. Build in the practice of good listening and good communication. There is currently great emphasis in skills training in listening and communication for students, including the use of simulation labs where young practitioners practice delivering bad news to standardized patients and are then mentored and coached into how to improve is one example. What is missing, however, is the modeling, coaching and mentoring and the systemic structures that reinforce and support this skills training. Young practitioners need to see good listening and good communication modeled by nurses, residents and doctors in daily practice as they move through their training, and they need to learn in institutions that allow the time and circumstances for good communication to occur.

8. A focus on teamwork and intra-professionalism is another important design element. This demands practice working as teams. The practical wisdom of modern medical practice is no longer a solo act: increasingly, wise decisions about the treatment of chronic illnesses or complex psycho-social problems depend on teams learning the skills to work together to see the different aspects of the context and the different interrelated problems of the patient and come up with wise suggestions, delivered wisely, for this particular patient. A learning environment needs to be designed which encourages practitioners to work in teams, to listen and communicate, to dialogue and brainstorm.

9. Continuity of relationships over time. Undergirding many of the design elements above is another design principle: allowing young practitioners a continuity of experience over time with their mentors and with their patients. The experience of such continuity over time encourages reflection. It allows practitioners to learn how to understand the thoughts and feelings of patients. Continuity also encourages the experience of trust building and loyalty which then allows a safe environment where learning can take place through trial and error, and young practitioners have the opportunity to practice mindfulness and being present.

10. Responding to critical incidents in real time. Mistakes, moral conflicts, difficult encounters, all present particularly powerful opportunities for wisdom development. How these experiences are integrated by individuals and organizations determine whether wisdom is gained.⁴² Creating opportunities for processing these situations in a way that fosters wisdom is therefore critical. Schwartz rounds, error disclosure and peer support programs, involving clinicians in the productive response to medical errors, are all ways to encourage wisdom-development in the wake of these difficult circumstances.

The Design Elements at Work. There are fascinating cases of such institutional re-design aimed at encouraging medical practitioners to learn not only the scientific knowledge and technical skills to practice medicine but character traits and moral skills to practice wisely. The two we have picked are meant to illustrate how system re-design can encourage the learning of practical wisdom.

Case #1: The HMS Cambridge Integrated Clerkship.. One illustrative experiment in creating a wisdom-inducing training experience—creating what the authors sometimes call a “wisdom matrix”—are what are, infelicitously, called Longitudinal Integrated Clerkships programs, or LICs.⁴³ One of the most important pilot programs of this type, the Harvard Medical School-Cambridge Integrated Clerkship (CIC) at the Cambridge Health Alliance, was examined specifically for the way it encouraged by design the learning of practical wisdom.^{3,43}

One motivation for the creation of this program by people like Dr. Malcolm Cox (then dean of medical education at Harvard Medical School), Dr. David Bor, Dr. Barbara Ogur and Dr. David Hirsh was to reverse the well-documented moral erosion and decline of empathy among medical students during their third year of medical school. There were many built-in, systemic reasons for this loss. In the hospital, students witnessed overworked and tired doctors focusing only on the disease process rather than the person experiencing the disease, they had little time to mentor students. Students unfortunately often witnessed demeaning language which de-humanized the patients [“crocks” (a hospitalized complainer whose illness is largely imaginary), “beached whales,” (obese patient unable to do much for themselves), “gomers” (get out of my emergency room).] Students were encouraged to deliberate and reason quickly, but not to reflect; and worse, they were being encouraged to get the answers right for the wrong reasons—to please or impress the resident or attending, not because it really mattered for their care of the patient. “They need the science,” explained one program director. “That’s critical. But if it’s only the science they learn, it’s a wash. They come in being idealistic and patient centered. But they leave burnt out and cynical.”

Those who created this program never said “we’re teaching good judgment” or “we’re teaching empathy” because, they explained “you can’t teach judgment; the best you can do is cause it to be learned.” They created an environment—a set of experiences—which caused wisdom and character to be learned. The program relied heavily on creating a moral medical community with apprenticeship—medical and moral—at its core. It was designed so students learned the medical science, the clinical judgment, and the dedication, compassion and wisdom to stem ethical erosion.

At the heart of the program was a re-design of the relationships between the doctor-teachers and the students, between the students and the patients, and among the students. Instead of a training model based on immersion in hospital wards all day, the students spent every morning in four out-patient clinics (internal medicine on Monday, psychiatry on Tuesday and so on) working one-on-one with the same doctor for the whole year.

Their doctor mentors in the clinic guided the students as they learned to do patient histories, then work up the patients prior to examination; then do diagnoses; and finally recommend treatments—all this under the guidance of their doctor mentors. Making the students responsible for actual patients in this environment taught them to care by caring, taught them the hows and whys of listening and empathy and good communication

because the dispositions and skills were not theoretically important but actually important for *their* patients.

Such learning is reinforced in “morning rounds” when the 12 to 15 students in the program gather from 7 until 8:30 to present “their” cases. They learn to do a differential diagnosis with the other students and a faculty facilitator working along with them. The facilitator acts as a coach, scaffolding the process: Here are the steps. Lets do one. OK: you try it. But as they try it, and struggle through it, there is a coach there—wise enough to know when to interrupt and when to let the process, warts and all, unfold. The doctor-coach balances silent listening with pushing and nudging....OK: what is missing? What’s the alternative?

They work together and learn the skills of listening, empathy, cooperativeness and collegiality necessary to work as a team. They leave the morning rounds puzzled after the first day: the students presenting the cases do not reveal to actual diagnosis. That is for the team—the class—to work out on the second day when they move on to treatment and whether it worked or not. Ethical issues are not add-ons but integral to their cases: I know that my patient’s diabetes is going to get worse and that he will be back in a few weeks because he is at a men’s shelter and one of the major foods that is around all the time are the doughnuts....what can I do, what should I do?

Such learning was premised on trial and error: when the third year students explained their diagnosis to their doctor-mentors in front of their patient it was expected they would make mistakes: this was part of the learning through trail and error that a good apprenticeship always involves. The learning was designed to allow for such trial-by-error-experiential-learning without putting the patients at risk. And it was not just a simulation lab with standardized patients. Students were learning to recognize actual mistakes with real consequences; they were gaining the courage and the know-how to admit them; to figure out why they made them; to imagine what they might have done differently. Without an experiential process like this it is difficult to “learn from experience;” and without this learning there is no encouraging practical wisdom.

Learning to be reflective is also built into the program. And such reflection was both cognitive and emotional. Students are encouraged to reflect about how they felt, about their ambivalence and conflicts; to think about why they felt this way and how they did or did not control and guide their emotions or how the emotions took over. They learn to recognize how their emotions effected their understanding and their choices.

Learning how to balance empathy and detachment was built into the process and the students and their doctor-mentors could talk over each case after the patient left. One student explained how his clinical mentor would regularly arrange for a short afternoon walk on the day of his clinic to continue the discussion, reflection, and compare this patient to other cases and other such decisions. “I am not just talking about the importance of trial and error in learning the technical part of clinical wisdom,” the student explained, “but also the ethical part of clinical wisdom. And I am suggesting that the way you learn wisdom in both cases is the same: through the experience of getting it

wrong and reflecting on why you got it wrong so you can learn from your mistakes. I'm talking about the many ways to get it wrong when it comes to counseling a patient, to figuring out how to get them to accept treatment, to allaying their fears, to giving them hope, to helping them make good choices—knowing when to choose for them, knowing when to let them choose, and helping them make those choices. These are the kinds of daily ethical questions so important for good doctoring.”

Students are learning the habit of being reflective and the skills (*how* to be reflective) by practicing being reflective under the guidance of these coach mentors. The doctor-mentor-coaches encourage this learning by getting them to ask the kinds of questions that helped them develop ethical sensitivity: How do you think the patient felt when you gave the diagnosis? How did you feel? What kind of response did they make (in words or body language)? The doctor-mentors also pushed the students to reflect on their ethical judgments: What was the rule or principle here? Did principles conflict: was patient autonomy at odds with patient health because you doubted the patient was capable of making good choices? Why should we make an exception to the rule or best practice? How much truth should you tell this patient and when? Why did you nudge the patient this way (toward drugs and not diet; toward wait and see instead of surgery)? Concomitantly doctors encouraged students to ask them questions and told their own stories of wrestling with difficult ethical issues.

At the Cambridge Integrated Clerkship Program students begin to learn the moral skills and will they will need to have real clinical wisdom at the very moment when they first start treating patients in their third year. They are doing this by immersing themselves in an apprenticeship based moral community that teaches the technical and ethical skills needed make good medical decisions. They are put in a practice situation where they learn through their mistakes; but scaffolding provides initial guidance in which they learn the moral rules before they learn how to bend and break them. They get constant coaching (and the coaches also provide safety nets). They learn about loyalty and trust and the courage to admit mistakes and make tough calls because their mentors are living these virtues and demanding they live by them too. They learn the skills and disposition of empathy and compassion and detachment because this is what they try to practice and this is modeled for them—and if its not, they get to talk about this in their Patient-Doctor class. And, critically, they learn how to reflect so that they can learn from experience.

What the Cambridge Integrated Clerkship program has done for the faculty and third year students in its program is create exactly the kind of moral community that Hafferty writes about.^{39,40} Character and practical wisdom are *built into the very fabric* of the everyday experience of medical students.

Case #2: The Phronesis Project at the University of Virginia School of Medicine

A second example of designing for wisdom is the *Phronesis Project* at the University of Virginia School of Medicine. This pilot project is designed to foster

capacities for wisdom formation from the beginning of medical training, through longitudinal formative relationships with a physician mentor, early introduction of reflective practices, and longitudinal student-patient relationships sustained throughout the four years of training.

In most medical schools, students learn the basic science of medicine during the first two years of training, and then move into the clinical arena for the final two years. Students come in to medical school full of idealism and altruism, eager to enter into a profession of service to others, and primed, very often, with important and relevant real life experience. But during the first two years of medical school, with a total focus on the science, and a near-total discounting of their prior life experience, their original intent can begin to erode. With little or no patient contact, they can completely lose sight of why they wanted to be a doctor in the first place. They have little or no hands on experience with patients in which to seat their new medical knowledge. Their cognitive capacities are stretched with massive amounts of information, but they have little time or training in how to reflect on that information, or how to apply it in the context of a real life. Finally, they are, for the most part, living in a world of right and wrong answers, with little opportunity to learn to manage the true ambiguity of real life medicine.

The Phronesis Project at the University of Virginia School of Medicine was designed to turn this corrosive experience into a wisdom-inducing environment that would encourage the learning of knowledge and professional capacities in rigorous and stimulating ways. At the heart of this pilot project is a small group seminar—a wisdom formation learning lab—that is part of the required four year Clinical Professional Development (CPD) course. This longitudinal learning lab is designed to encourage the capacity for practical wisdom that is at the heart of professional formation. At its center are two long term relationships: student-patient relationships that are sustained throughout the four years of training, and a physician-student relationship to provide ongoing mentorship of the process. The Phronesis Project expands to all four years of medical school the kinds of continuous, “longitudinal” relationships are at the center of the third year medical clerkship program at the Harvard CHA program described above.

The 12 students who sign up each year for the Phronesis Project seminar in the CPD have a specially designed CPD curriculum to make time and space for the wisdom formation learning lab. Students are assigned two patients, one adult and one pediatric, which they follow for four years. Students are integral members of the patient’s interdisciplinary care team, which would include the primary care and specialty physicians, nurse coordinator, social worker, pharmacist and health outreach workers. Students meet together monthly for specific applied portions of the Phronesis curriculum, including mindfulness and reflective practice, motivational interviewing, advocacy, population health, justice and health, patient safety, and narrative medicine, all applied specifically to their patients.

In year 1 students begin with a house call to their patient, accompanied by their physician mentor, to get to know their patients through doing a narrative history. Unlike the usual medical history, which focuses on the patient’s illness, a narrative history is

focused on the patient's story: who are they, what is important to them. This first introduction to their patient is as *a person* rather than an illness, giving the students a context in which to develop an *empathetic and compassionate* relationship with this patient. At the same time, in the seminar learning lab, students are learning the practice of *mindfulness*, loving-kindness meditation, practicing self compassion and compassion toward others.

The student's second task with their patients is to accompany their patients through an encounter with the medical system. They have now bonded with this patient, and as they accompany their patient through the medical encounter, experiencing it through their patient's eyes, they are beginning to practice *perspective taking*, another wisdom capacity that is then re-enforced in their seminars. Through that perspective taking, they see the barriers that patients face in accessing medical care, and they participate in a design-thinking process to re-design parts of the health system to reduce those barriers their patients face.

Midway through their first year, after seminars on advocacy and on the social determinants of health, they begin to serve as advocates for their patients. Many of their patients face significant socioeconomic barriers to achieving good health, and the students learn first hand what injustices and inequities exist in our communities and how they affect peoples' health and wellbeing. They begin to see the role of the physician in working toward *the greater good* in society.

Toward the end of the first year, after seminars on motivational interviewing and goal setting, students begin working with their patients on a particular goal that their patients have chosen, and they see first hand the complexity of *discerning* an individual's values and goals for their lives, and how medical decisions must be individualized based on these larger goals.

Each week the students "check in" at the beginning of the CPD seminar with a brief update on their patients. They have an opportunity to problem solve or reflect on something that has happened that week. By the end of the first year, the students have an in depth clinical seminar in which they discuss their patients more longitudinally with their fellow students and mentors, reporting on what is going well, what is particularly challenging, what has worked and what is *not* working. The students reflect together, help each other, and learn from each other's perspective and experiences. In this process they are developing capacities for learning from mistakes, recognizing their limitations, and working as a team. The wisdom capacities of *humility, tolerance for ambiguity and complexity, applying knowledge to right action in context*, are all forming through these experiences.

As students' medical knowledge and clinical skills begin to develop in their second year, they take on a slightly more clinical role with their patients. Their specific tasks with patients include helping their patients with both understanding of and adherence to treatment plans. The students begin to experience the complexity involved in designing a workable treatment plan. That complexity involves figuring out treatments

which their patients are actually willing and able to follow. And that in turn involves understanding the obstacles to such “adherence” because of health literacy, belief systems, culture, economic and social barriers. Working longitudinally with their patients on adherence and behavior change often brings about a sense of frustration or a sense of failure. Mentors (and other students) then have the opportunity to help engage the student’s learned practices of mindfulness, motivational interviewing, perspective taking, and compassion. Students are encouraged to reflect on how they could have done things differently, and to try different approaches, to improvise and think outside the box. And because this is a 4 year long relationship with their patient, these students have the opportunity to take the long view, to see the effect over time.

Perhaps one of the most critical aspects of this medical school re-design is that the student’s experience is grounded in four year long relationships with both patients and a mentor. Wisdom is developed in a context. The value of having an ongoing context is perhaps more critical than we have recognized in medicine. Medicine used to be an apprenticeship. Doctors cared for the same patient for their lifetime. There was context over the course of many years. This is no longer the case in most medical schools, where students will care for a particular patient for a few days, at most a few weeks. The *Phronesis Project* students care for their patient for four years, and a lot happens to people in four years. They get sick, they get well, sometimes they die, and the students experience all of this alongside their patients, with their mentors coaching them throughout it all. In their reflections, students are recognizing the value of this longitudinal relationship with both patient and mentor:

“The one memory I’ll hold closest to my heart is how Mr. B believed in me even when I felt like I had no idea what I was doing. My nerves got the best of me in my first patient visit and I remember feeling like a fraud afterwards and questioning how I could ever be any help to Mr. B. But Mr. B had nothing but positive things to say about our meeting and as our rapport grew stronger over the ensuing months, I understood the impact of me being there for him.”

“What made this relationship so special to me was that we had a chance to talk through our days and our lives; we were two polar opposite personalities coming to terms with the people we’ve become. We were almost perfect complements - I’m at a point in my life where I have so many questions and so few answers, but my patient (age 80) had all answers and was struggling to find more questions to ask of himself. And so I listened. And I learned.”

In the third and fourth years, students meet monthly with mentors to discuss their patients, their experiences in the clerkships, and their moral and clinical conundrums. What has become clear is the student’s need to put in proper context the experiences that they have throughout their clinical training, many of which conflict with their deep values. Through their longitudinal patient relationships they have experienced the importance of the patient’s life story, the critical nature of context in medical decision-making, and they are particularly sensitized to how patients can become diagnoses, or data points, rather than human beings with families and context. They are aware of their

own histories and how they, for good or for limitation, influence their capacities to “be with” their patients in a therapeutic relationship, and bear witness to their patient’s experiences. They find their sensibilities challenged by the current context in which medical care plays out. In monthly meetings we are able to work through these “balance and discernment” challenges. Students are encouraged to challenge each other, and themselves. They are encouraged to see their failures as true and critical opportunities to grow and mature as clinicians. Their mentors are encouraged to share their failures and limitations, and their own process of continual balancing and discernment in the quest for wisdom in doctoring.

The UVA *Phronesis Project* is now entering its fourth year. Time will tell if these students have a leg up in wisdom development, but early experience suggests that the project has at the very least successfully engaged them in the quest.

In this paper we have outlined some of the everyday decisions doctors make that require practical wisdom. We defined character traits and moral skills that are constitutive of practical wisdom and why they are critical to medical practitioners who want to practice well. We used a case to illustrate these character traits and moral skills in action. Our focus then turned to the question of how medical practitioners learn practical wisdom and how such learning can be nurtured, outlining some of the design elements which encourage practitioners to learn practical wisdom. We argued that practical wisdom in medicine can be learned, specifically mentored, in a longitudinal focused process intent on integrating critical virtues with those capacities that enable the exercise of those virtues through practical wisdom.

Doing medicine well requires practical wisdom. Too often medical schools and institutions corrode the very wisdom that good medical practice demands. But that situation can be turned around by designing for wisdom.

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