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REFLECTIVE HEALTHCARE PRACTICE

Claims, Phronesis, and Dialogue

Phronesis comes into being but has no specific beginning; we evoke it, but any description seems incomplete. One evocation of *phronesis* is illustrated in a story retold by the Zen teacher and poet Norman Fischer. The story involves a dialogue between two Zen masters—it's important to note this dialogue is not between a student and a teacher but between two masters—Guishan, also referred to as Shan, and Daowu, also called Wu.

> Guishan asked Daowu, "Where are you coming from?"
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> Daowu said, "I've come from tending the sick."
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> Shan said, "How many people were sick?"
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> Wu said, "There were the sick and the not sick."
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> "Isn't the one not sick you?" Guishan asked.
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> Daowu said, "Being sick and not being sick have nothing to do with the True Person. Speak quickly! Speak quickly!"
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> Guishan said, "Even if I could say anything, it wouldn't relate." Later Tiantong commented on this, saying, "Say something anyway!" (Fischer, 2008, p. 66)

Fischer (2008) offers several observations about this story, although he presents the story less as a text to analyse and more as what I'd call a *companion*—that is, a story to live with over time and in the different circumstances that life presents. Fischer recommends "letting [such stories] work on us, instead of us working on them" (p. 63). But such an approach doesn't exclude a level of interpretation that begins with Fischer noting that although visiting the sick is a great spiritual practice, it's possible that Daowu was not visiting the sick at all. Instead, *sick* in this dialogue is used in the sense of the first Noble Truth of Buddhism—that all beings suffer.

The teaching question, or *koan*, that Fischer takes from the story is: "Who is sick?" This question is not intended to be answered in so many words; again, the

E.A. Kinsella, A. Pitman (eds.), Phronesis as Professional Knowledge:
Practical Wisdom in the Professions, 53–60.

point is to let the question work on us, instead of us working on it. But as the last part of the dialogue emphasises, although nothing relevant can be said, silence also is not an option. So Fischer (2008) offers a sort of answer to his *koan*:

> Who are the sick? The ones who have forgotten the stories of suffering and pain, who think that they themselves are not sick. These are the sick ones; these are the ones who suffer a lot. Who are the ones not sick? These are the ones who know the stories, who know that they are sick, that we all are sick, and who have sympathy. They know the world is a hospital ward and we are doing nothing but tending the sick, ourselves included. (pp. 66–67)

Fischer would be the first to acknowledge that he didn't discover any of this. It is very ancient teaching. When I had cancer back in the 1980s, I'd read enough of this teaching to attempt to say some of the same sorts of things in the book I wrote about my own illnesses, *At the Will of the Body* (Frank, 1991). My working title for that book was *A Dangerous Opportunity.* One danger of being diagnosed with a disease is thinking that only *now* you are sick, and that being sick with a disease is something special. One opportunity you have is to realise all the ways your life has always been sick, and then expanding that realisation to recognise that the sick are all around you. Sickest of all are those people who are most convinced that they exist on the other side of some great divide between themselves and your condition of illness.

I begin with Fischer's (2008) story of Shan and Wu for two reasons. First, I want to say to healthcare workers: Take this question—Who is sick?—and keep it close by so that it can work on you. Let it in, and become shaped by it. Mainstream medicine reduces the answer to this question to the identification of a diagnosable disease. Like all reductions, that answer is useful, but it also authorises us to stop thinking at the point at which wisdom needs to supersede knowledge, which is when phronesis begins. My second reason is to exemplify one form of reflective practice before I talk about reflective practice, which I will now do.

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Reflective practice begins with interruption. I remember once talking to a clinical ethics colleague, William May, about my frustration with one of the oncologists who had treated my mother-in-law when she was dying. This oncologist simply would not stop and listen to her questions, or the family's questions, or anything. "You threw him off his rhythm," Bill said to me, and that reply expressed considerable wisdom about medical practice. All of us have a rhythm as we go through our daily tasks, and we resent anything that throws us off. In the course of any present task, we are anticipating the next task, and the pace of the present task takes that anticipation as its metronome. Living in such anticipation is a very un-Zen way to be, always subordinating the present moment. But it gets things done, whether that task is house cleaning or medical rounds.

Reflection interrupts that flow. It is a carved-out space in which we ask ourselves what we're doing, and *who* is doing the things that seem to be getting done. In these reflective moments, the subject of action and the object of action are linked; not quite merged, but fully dependent on each other. You can't think about one without questioning the other. Daowu and Guishan both know this, which is one reason why Guishan's question—"Isn't the one not sick you?"—is very funny, in the spirit of *koan* questions to which you can answer neither yes nor no. Both answers are true and not true, which is why the question does not require an answer as a response, at least in any usual sense of an answer. What the question does require might be better described as an interruption. In the space of this interruption, we need to ask what more is being asked than can be addressed by any answer.

What needs to be interrupted is the temporal flow in which what is supposed to happen next dominates the present. And beyond that, what gets interrupted is what sociologists call *typification*, which is one of the main ways that humans make manageable the unmanageable complexity of the reality we face, especially the reality of other people in all their differences. The biographical uniqueness of every other person is simply too complex for humans to deal with, so we categorise people into types, usually according to what we think they expect of us or what we expect of them. Each type has its rules of interaction: how much time to spend, what to say and what need not be said, and so forth.

The sociologist Harvey Sacks (1974) took the idea of typification further and talked about *membership categorisation devices*. What Sacks (1974) noticed was that in much ordinary conversation, speakers refer to people in ways that require the listeners to decide what membership category those people belong to. Sacks's famous example was a child's very short story, "The baby cried. The mommy picked it up" (Sacks, 1974, p. 216). No personal pronoun restricts the noun *mommy*, so the story is ambiguous as to whose mother is referenced. Sacks claimed and subsequent scholars agree that most of us hearing that story assume the woman who picks up the crying child is that child's mother. She could be another child's mother, but most of English-language speakers will intuitively decide she is the mother of the child she picks up. And here is Sacks's point: having made the membership-categorisation decision, we will stick to it and require considerable persuasion before we entertain other possibilities. So, this story shows another way we make an unmanageable world sufficiently manageable to live in, again, whether we are cleaning house or practising medicine.

Reflection first interrupts the temporal flow of yielding to the demands of *next*, and then it disrupts the processes of typification. Reflection asks: Who am I putting in this category of *sick*? What makes them members of this category, and others not members? What is the principle of my categorisation? I want to emphasise what was gently pointed out to me by the observation that my questions were disrupting the oncologist's rhythm. To stop somebody who is going about his or her business and ask them what they are doing—and worse yet, *who* is doing that—is beyond annoying. Such interruptions recall why people were sufficiently annoyed with Socrates to execute him. In his distinctively rational but Zen sort of way, Socrates practised interrupting people and asking them to reflect on what they were taking for granted, especially the categories they used to account for their activity.

Those who practise Socratic interruption risk Socrates's untimely demise. That is exactly what I will now risk, as I try to specify more closely what kinds of questions healthcare workers might ask themselves, if they were to practise reflection. *Who is sick?* is a fine question for meditation, but professional reflections can also be more task-specific. At the end of these more specific questions, however, we can still return to *Who is sick?*

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During the last decade, I have had the opportunity to spend a lot of time talking to nurses and physicians about their work. One realisation for me has been the many different responsibilities clinicians have in any encounter with a patient. I think these responsibilities are usefully thought of as *claims* on the healthcare worker. Each claim calls on the clinician to act a certain way. Some of these claims are complementary, but some can be antithetical to other claims. My list has six claims, and these six are not exhaustive.

First, *practical* claims. Patients, but also colleagues and insurance companies, expect an outcome. The healthcare workers are supposed to get something done, whether that task is diagnosis or intervention.

Second, *professional* claims. Physicians work under the most stringent expectations to meet the anticipated judgements of their peers, both locally and extensively; the professional claims on nurses seem more institutional and team-based. These expectations might be explicit—as in best-practice guidelines issued by professional associations and to which physicians are legally responsible—or they might be implicit, as in what colleagues say about you in the lounge or locker room. I have to remind myself how incredibly peer-oriented medical culture is, which I perpetually underestimate.

Third, *scientific* claims. Medical practice is supposed to be based on science, both basic science and the more specific clinical findings known as *evidence*, as in the phrase, *evidence-based medicine*. Physicians, as those who have the final responsibility to prescribe treatment, expect themselves to fulfill those responsibilities according to science, or to have very good reasons for any deviation.

Fourth, *commercial* claims. Included here are many claims, from the sorts of direct financial interests that raise the eyebrows of ethicists—such as physicians having significant personal investment in the pharmaceutical company whose drugs the physician prescribes—to the more mundane claims of sustaining office income. The latter may involve being answerable to an office manager who monitors the physician's productivity, or, if the physician owns his or her own practice, she or he needs to respect the claims of office staff whose employment depends on the financial viability of the practice.

Fifth, *ethical* claims. Here, I use ethics in the sense of bioethics: partially codified standards of practice concerning matters such as patient autonomy and consent, confidentiality, respect for dignity, and, at the extreme, non-maleficence. Physicians have all sorts of power with respect to patients, who have all sorts of vulnerabilities. Ethical claims involve the non-abuse of that power. For that reason, such claims are largely negative, phrased as prohibitions.

Finally are what I could call *moral* claims, using *moral* in the sense that Arthur Kleinman (2006) may have done most to refine in his writings on medicine. The moral claim that I emphasise most in my own writing is to *witness* the patient's suffering. In a perfect world, this claim would be complementary to the first expectation that physicians do something with a practical benefit, but a tension can exist between the two, as each makes fundamentally different demands in the physician–patient relationship. The moral claim often involves a very difficult task for physicians: *Don't just do something, stand there*. Or, better yet, sit there. Quietly. Either allow the patient to speak, or allow the silence to hold you both together. If the practical claim presupposes the greatest distance between the practising subject and an object that is practised upon, the moral claim understands what both subject and object share in their common humanity. They are both sick and both not sick. They both suffer and they both know stories that address that suffering.

Again, these six claims hardly exhaust all the responsibilities imposed upon and experienced by healthcare workers. Six are enough for now, and you can think about others. You can also think about which of these claims support other claims and which undermine other claims; when do healthcare workers find themselves in conflict as to which claim to honour? *Reflection*, in a more focused, applied sense, can begin by asking which claims are relevant in any medical encounter. Which claims ought to have priority in *this* encounter? How are different claims backed up, and do those backings give certain claims undue force, vis-à-vis other claims? How can each claim best be honoured, and when must some claims be allowed to fall into the background, perhaps the deep background?

Let me emphasise three points that seem to me to be crucial. First, at least all these six claims will be relevant in any physician–patient encounter. Second, in most encounters that I can imagine, some claims will militate against others. Third, no decision algorithm can prioritise among the claims. As I see it, the physician has pretty much only two choices. One choice is to organise the days according to a default setting with respect to which claims are honoured how. That is, look at the day as a big checklist and don't look back or even around, which is one description of residency training that imprints itself on physicians as a way of getting through their day. The other choice is to reflect enough that maybe, eventually, a kind of practical wisdom will develop that can never be fully articulated—again, it's never an algorithm—but is felt as a guiding force. The name that is increasingly given to that practical wisdom is Aristotle's term, *phronesis*.

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Why are professionals in diverse fields looking to phronesis as some kind of solution to problems they face? What do these people hope that *phronesis* can do for us? All kinds of answers are useful to consider, but I will propose only one. Simply put, consider the project of thinking that life's decisions can be made by plugging them into an algorithm; sociologists would call it the routinisation project. Unfortunately, solutions along these lines seem to cause as many problems as they resolve. Let me illustrate with several stories. The first is a fairly obvious story of what could be called non-*phronesis* or even anti-*phronesis* practice, and the later stories show the need for *phronesis* because what ought to be done is by no means clear.

An experienced dialysis nurse described a patient who did not speak English and was both especially apprehensive about dialysis treatment and in pain. He was agitated and pulling at the dialysis lines, so he was given a breakthrough dose of narcotic, according to a protocol. He fell into a calm sleep. As the treatment progressed, a floor nurse came by, noted on the patient's chart that the protocol called for him to receive an oral pain pill, and proposed to wake him up to administer the dose. The dialysis nurse objected that this was ridiculous—the patient was already asleep. She also pointed out that the patient's chart indicated a choking hazard. The floor nurse returned with a supervisor; the patient was woken and given the pill, by mouth, despite the choking hazard that was charted and written on a sign over the bed.

People tell clichéd jokes about hospital patients being woken up to receive pills so that they can sleep. But sometimes, it is not a joke. Regular medication to prevent breakthrough pain is good practice. But breakthrough pain was not the risk for this dialysis patient. The issue was not the patient's needs but the needs of the protocol. I call this story anti-*phronesis* because it's about overriding the claims of practical wisdom in favour of routines that have been decided upon without reference to the situation at hand but which are nevertheless applied. The story is almost too much of a cliché to be useful, but it did actually happen. And that it happened—that the protocol was so obviously lacking as a guide to action—is why people turn to *phronesis* as a better way of doing things.

What also needs to be emphasised is that *phronesis* does not do what protocols are intended to accomplish, which is to decrease personal responsibility for decisions that might be challenged. If, for this dialysis patient, the protocol had been followed and things had gone badly, the nurses would have been accountable, but they had a defence. If things had gone badly and the protocol had not been followed, their level of accountability would have increased. So accountability trumps both the patient's interest and the nurse's self-respect as a professional. Phronesis offers no such formal, juridical accountability. On the contrary, phronesis is precisely about taking personal responsibility that is based on expertise.

My other stories come from Tony Miksanek (2008), a physician practising in Illinois. Miksanek's article is titled "On Caring for 'Difficult' Patients," and the patients he describes really are difficult. Willy is a diabetes patient who demands that Dr. Miksanek do nothing more than renew his prescription for insulin and syringes. He refuses any examination or care. "If his chart is ever reviewed by the insurance company for quality of care," Dr. Miksanek writes, "I'm going to get dinged" (p. 1424). He concludes: "What makes me an ineffective physician in my mind is exactly the quality Willy deems vital in his primary care doctor. I'm easy" (p. 1424).

At the other end of the patient spectrum, the difficulty of caring for Mrs. Thomasina is that she exemplifies what Dr. Miksanek (2008) calls "testophilia" (p. 1424). She is convinced she needs every medical test she hears of, and she calls weekly to demand more tests. Those tests that Medicare will not cover she pays for herself. Dr. Miksanek writes: "Her faith in technology and medical science approaches medical devotion" (p. 1425). He also recognises that if "she isn't single-handedly bankrupting the healthcare system, Mrs. Thomasina is definitely putting a small dent in it" (p. 1425). He tries to resist her demands, "Yet she has a way of wearing me down" (p. 1425).

The third patient is Max, who not only has but also is a pain in the neck—the metaphoric nature of the physical symptom is significant. Max is angry with his employer and with workers' compensation. "Max sees himself as a victim," Dr. Miksanek (2008) writes; "Now I feel just like him—pessimistic" (p. 1426). Their appointments have a ritual quality: Dr. Miksanek fills out forms, and he gives Max a pep talk, although, as he writes, he does not believe it himself. At the end of their session, "We nod at one another without speaking a word" (p. 1427).

Care of these patients can be provided only on the basis of *phronesis* because these patients don't fit the accepted models of practice. But here we reach an impasse that I see as undecidable. Some might argue that what all three patients need is precisely to have a protocol imposed on them to force them to accept good care or to accept reasonable limits to care. I am convinced that such attempts would alienate the patients and either drive them to other physicians, where the same cycle would repeat itself, or drive them out of the medical system entirely. Unless that risk is taken—and in the not too distant future it may become an acceptable risk—neither *phronesis* advocates nor protocol advocates can claim to be right.

Dr. Miksanek's stories do not lead to any conclusion for improved care. No magic intervention is offered to make things right for any of these patients. Dr. Miksanek suggests that longer, less frequent visits might help, but those who reimburse the visits do not see things that way. He concludes: "Difficult patients and their frustrated physicians fail each other. We flop together. We lose hope. And there is no more worthless doctor than one who has lost all hope. Same holds true for a patient" (Miksanek, 2008, p. 1428). Where, you might ask, is the possibility of phronesis in the care of these all-too-real patients, who might also be students, or social-work clients, or any other type of what the British and Irish call service-users?

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To paraphrase Portia in Shakespeare's *The Merchant of Venice*, the wisdom of care is all too often strained, but nevertheless it continues to fall "as the gentle rain from heaven." That's a miracle we should celebrate. I hear that rain falling in Dr. Miksanek's stories of difficult patients. The quality of phronesis that I hear in these stories is the recognition that these people need care not in spite of all the ways they resist good medical practice but precisely because of that resistance. To put it in more abstract terms, Dr. Miksanek's practical wisdom informs his courage to remain in dialogue with imperfect patients, even to the point of recognising how their imperfections instigate his own.

Here, then, is a final koan about reflective practice. In Dr. Miksanek's closing, despairing comments about flopping together, is he dragged down by his patients, or is he dragged up? Say either and you miss the point. Speak quickly, as Daowu says. And, if you can think of nothing to say that relates, say something anyway, as Tiantong says you must, because these stories happen and your silence is not an option. Phronesis is what enables these sad, depressing stories to be equally stories of liberation, of duty, and of calling. Phronesis does not make these stories any less sad or less depressing, but might enable the professional who finds himself or herself living such stories to persevere.

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