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Response: Clinical Wisdom and Evidence-Based Medicine Are Complementary

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ABSTRACT

A long-debated question in the philosophy of health, and contingent disciplines, is the extent to which wise clinical practice ("clinical wisdom") is, or could be, compatible with empirically validated medicine ("evidence-based medicine"—EBM). Here we respond to Baum-Baicker and Sisti,¹ who not only suggest that these two types of knowledge are divided due to their differing sources, but also that EBM can sometimes even hurt wise clinical practice. We argue that the distinction between EBM and clinical wisdom is poorly defined, unsupported by the methodology employed, and ultimately incorrect; crucial differences exist, we argue, not in the source of a particular piece of clinical knowledge, but in its dependability. In light of this subtle but fundamental revision, we explain how clinical wisdom and EBM are—by necessity—complementary, rather than in conflict. We elaborate on how recognizing this relationship can have far-reaching implications for the domains of clinical practice, medical education, and health policy.

In their insightful article, "Clinical Wisdom in Psychoanalysis and Psychodynamic Psychotherapy," Baum-Baicker and Sisti present a distinction between "formulaic knowledge," as dictated by standard rules, and "phronesis," the more flexible procedures based on an Aristotelian practical wisdom above and beyond the standard rules, which includes the occasional sidestepping from the rules in order to make optimal medical decisions.

The authors provide useful insights from experienced practitioners regarding wise clinical practices in psychoanalysis and medicine more generally. Their call for greater use in clinical education of paradigm cases, mentorship, tolerance of uncertainty and paradox, kindness, and empathy are well worth heeding. The influence of their wise article, however, would likely be greater if their methodology were less accepting of clinicians' potential misattributions

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of wisdom to what Dostoyevsky's Grand Inquisitor in *The Brothers Karamazov* describes as authority, mystery, and magic.² They should also divorce their otherwise mindful analysis from a false dichotomy between apparent uncertainty, misattributed to single case-based knowledge, and the certainty all-too-often misattributed to evidence-based medicine.³ We take a closer and more critical look at the methodology employed, as well as distinctions and conclusions made, paying special attention to how physicians should appraise and value evidence in medical decision making.

CRITICISMS OF METHODOLOGY

Although the authors purport to provide useful information from interviews of peer-rated wise practitioners, care should be taken with regards to the following methodological points:

Few details in Baum-Baicker and Sisti are provided regarding the methodology used. The authors describe their process as follows: "Participants in the Wisdom Project were nominated as therapists who were judged as having 'clinical wisdom' by their peers." Baum-Baicker and Sisti appear to accept these nominations without question and provide no explanation as to their reliability or internal or external validity. Nor do the authors detail how independent peer evaluations of wise practitioners were carried out; although they speak of "a review and qualitative coding of the interview transcripts," they do not explain this further. Clear and transparent descriptions of methods are crucial so that other scientists and clinicians can replicate the results of the study and extend its main findings for new purposes.

The authors describe historical perspectives on wisdom from disciplines such as philosophy and psychology, but after failing to find consensus on a precise definition, they decide that the "desideratum of experience" is the tie that binds these different descriptions. However, the authors do not specify the statistical (or even nonstatistical, but still objective) point at which practitioners are classified as experienced or "wise enough." Nor do the authors provide an operational definition of the concept of wisdom

that states precisely what, other than the nebulous and subjective notion of "experience," separates the wise from the unwise. Certainly not all experience creates wisdom. Furthermore, little statistical explanation is given for how the authors decide at which point a given criterion for practical wisdom qualifies as the consensus among wise-rated practitioners. Finally, the authors do not discuss possible alternatives, objections, or improvements to the methodology they employ. In presenting their method of peer evaluations for wisdom, for instance, they might have addressed whether or not peer evaluation is, in fact, a sufficient or optimal method for determining whether practitioners are wise, or whether another measure of evaluation, such as patient rehabilitation success rates (or another outcome measure), for the practitioners in question, or a "wisdom assessment questionnaire"—used in place of, or in addition to, the peer evaluation method—may be more accurate.

Therefore, the interpretability of the results remains limited, since we cannot be sure the perspectives on wisdom proffered are indeed the consensus among wise-rated practitioners, nor can we ascertain the extent of consensus even within the criteria articulated. Otherwise we are left with the possibility that, as occurs in some continuing education courses, at least some of the teachers who get the highest ratings are those who provide only continuing validation, rather than challenging education to clinical peers attending as students.

DICHOTOMY: EVIDENCE-BASED MEDICINE AND CLINICAL WISDOM

The Argument

The article delineates a divide between technical and formulaic methods, on the one hand, and clinical wisdom on the other. Stated differently, it establishes a sharp dichotomy between scientific, evidence-based medicine (EBM) and clinical wisdom. The authors indicate that they agree with the following view put forward by Brendel (our emphases in italics):

When working on the scientific side of the science/humanism divide, the psychiatrist aims to practice *evidence-based medicine*

and employ a well-demarcated set of explanatory concepts to achieve unified, empirically supported accounts of human behavior. But exclusion of alternative explanatory concepts *may be detrimental*. . . Narrowly focused, scientific explanatory models in psychiatry may be *flawed* and *inadequate* insofar as they restrict the clinician's flexibility in making diagnoses and implementing treatments.⁴

This pragmatic approach implies that standardized methods are different from what is referred to as "humanism," and suggests that, if employed too stringently, they can hinder or harm the flexible practice of clinical wisdom. The authors state, "Indeed, technical and formulaic methods of psychotherapy seem to be antithetical to the practitioner's ability to draw upon clinical wisdom and experience, precisely because they rely heavily on an ostensibly 'objective' scientific process or method."

The authors also claim that EBM is deficient when dealing with individual patients: "technical knowledge will not suffice in the face of an individual patient's unique experience of psychic pain." In sum, technical knowledge is framed as a rather different—if not completely different—kind of knowledge from clinical wisdom, both in source and application.

Although these claims seem reasonable and even intuitive, they employ a false dichotomy. The dichotomy springs from a fear that EBM will somehow override nonscientific practices, although the authors can provide little evidence for why this would be the case. We believe that their view, by no means the only of its kind (for example, see Cassell⁵), is often rooted in the desire to preserve the mystique of nonscientific professionalism. A more nuanced view of the relationship between EBM and clinical wisdom is needed. More specifically, we share Parker's view that clinical experience is not its own kind of *sui generis* knowledge.⁶ What matters, as Parker argues, is not the source of the knowledge, but its dependability.⁷ Dependable knowledge necessarily comes from a pluralistic variety of sources, yet will have to pass some threshold criteria for being considered safe and effec-

tive in the clinical realm. In other words, EBM and other knowledge are not necessarily different; EBM is, by definition, less prone to distortion and bias and has passed a more rigorous standard of professional reliability.

Clarification

First, any "technical or formulaic method" has embedded in it some kind of wisdom. After all, methodologies are not static givens that come fully formed at the inception of a field. Rather, they are formed after years of accumulated wisdom garnered from practicing an art and testing this art against standards of efficacy and safety; these methods are either molded or otherwise replaced throughout the evolution of medical practice. For this reason, it does not make sense to form a dichotomy between EBM and clinical wisdom, since experienced practitioners are those who deeply understand and are particularly accomplished at employing all facets of their practices, which are themselves embedded in years of wisdom. Even those who diverge from standard practices must know exactly what they are diverging from before they can make these kinds of risky decisions. As editor in chief of *International Journal of Nursing Practice*, Alan Pearson, observes: "Evidence-based practice involves giving due consideration to the best available evidence. . . . Patients/clients value the *technically, scientifically informed* practitioner who is also *clinically wise.*"⁸

Second, in his lucidly argued paper, "Whither our art? Clinical wisdom and evidence-based medicine,"⁹ Parker efficiently refutes the kind of dichotomy presented by Baum-Baicker and Sisti. We explain here some of the main points from his argument that are relevant to our discussion. Parker explains why the claim that EBM can be detrimental to clinical wisdom is unfounded; namely, one would first need to prove that the introduction of EBM has lowered the consideration of the patient's wishes in doctor-patient interactions:

If this is phronesis, then the charge that EBM erodes the importance of clinical judgment loses force, since it would require the demonstration (depending on evidence) that

during the decade of EBM's ascendancy, patients and doctors have engaged in *less* interaction and negotiation concerning values and preferences than previously. I am not aware of any evidence that this is the case. Those who suggest that phronesis takes into account what EBM cannot, do not thereby demonstrate any deficiency of EBM.¹⁰

Counter to what is argued by Baum-Baicker and Sisti, Parker explains that EBM and clinical experience are not actually different kinds of knowledge; the presence of one approach does not exclude the other.¹¹ In the first place, it is important to form a distinction between things that can be tested empirically and things that cannot; some things are simply too difficult or impossible to test empirically. Knowing what is testable and what is not can prevent unfair criticism, misunderstanding, and confusion regarding the validity and extent of EBM. Parker writes, "we must carefully distinguish those things which EBM is capable of downgrading because they are difficult to measure (such as pain), from those which it logically cannot."¹²

Given advances in the psychological sciences (explicit and implicit behavioral measures, cognitive information processing, and neural measures), it is important to not prematurely give up on finding ways to empirically measure or operationalize subjective states. As for those aspects of medical treatment that are testable, we have every reason to pursue these aspects empirically and incorporate the evidence gained into our treatments, precisely because this evidence can increase our clinical efficiency and safety, not because it detracts from it. As Parker states:

It may be that unsystematic, anecdotal, personal knowledge of a problem like loneliness is the best evidence (Sackett et al., 1996) which we have at present, and according to EBM, it should be currently managed on the basis of such knowledge. However, if we regard loneliness as the kind of problem best understood by a means which is essentially different from EBM, we would not be motivated to undertake the variety of empirical studies which could provide further helpful data in addressing it.¹³

This does not mean other factors, such as circumstantial information or patients' preferences, must be removed from the equation completely—or even partially. This unnecessarily confuses the concept of evidence, which is based on populations, with the treatment of individuals, who can benefit from evidence taken from populations. The wisest clinician can make more-informed decisions by knowing the available evidence for populations as a whole and for the inevitable individual differences within populations. Parker clarifies:

First, any increase in efficiency, *ceteris paribus*, will benefit individuals. Second, EBM does not relegate the individual but must begin with and depend on him or her, since the particular characteristics of the individual determine which evidence will be relevant to that individual's case (Reilly et al., 1998). But the dynamic relation between individual and population studies is a necessity, since purely individual characteristics (I am not talking here about individual *preferences*) not anchored in some wider pattern cannot be action-guiding. This means that the frequent challenge to EBM—that in treating individuals, physicians must make inferences from aggregate data which puts the evidence at a remove from actual practice (Tanenbaum, 1999, p. 760)—loses its force. The fact that trial randomization aims to render any individual differences inconsequential is similarly brought against EBM, but loses significance for the same kind of reason—the elimination of individual differences in trials does not render trial data inapplicable to individuals; rather, it makes it applicable to the extent that individuals share relevant characteristics with trial participants.¹⁴

In this way, we can see how other statements by Baum-Baicker and Sisti that try to emphasize the false dichotomy between clinical wisdom and "formulaic methods" are similarly imprecise. Here, the malpractice of the pharmaceutical industry is construed as evidence for the emergence of "marginally effective formulaic methods" (our emphases in italics): "both the conceptualization of patients ('clients') as

consumers and the demands placed on clinicians ('providers') by insurers for quick, standardized, and *marginally effective* treatment has perpetuated the rise of *formulaic methods*."

Again, this view suggests that formulaic methods are somehow separate from and hindering to experiential knowledge. Firstly, for the reasons we have mentioned above, they are not; experiential knowledge, when adequately studied, will be incorporated into rigorous empirical methods, as it is in the rest of the experimental psychological sciences. Secondly, the unethical manipulation of clinical evidence or methods is not a fault of the principle of EBM itself. Rather one can understand the basis for its unethical nature because such practices in the first instance falsely construe the *empirical evidence* under question. The unethical manipulation is due to the complex amalgam of conflicts of interest within pharmaceutical companies that employ misleading practices in an attempt to gain more profit, the institutions meant to control this illegal behavior, and the marketing forces that inspire a consumer society in which patients are depicted as free agents empowered through the self-determination of choice.¹⁵ Controls and precautions have been enacted to limit these manipulations in the service of more accurate, systematic, and evidence-based clinical guidelines (for examples, see Brody and Light; Goldberg; and Green and Kesselheim¹⁶). It should therefore be emphasized that EBM itself is not to blame when such controls fail or are not enforced in the first place, but, rather, it provides the epistemic basis by which one can in the first instance recognize the manipulation created by nonobjective data.

Undermining the importance of EBM also confuses the medical interests of patients with their interests, over all. As Parker points out, "preference is independent of medical certainty."¹⁷ Indeed, often patients might want exactly what is—given the available evidence—medically the worst for them, especially if they are uninformed. It is the practitioner's responsibility to know when this is the case, so as to help patients make the most informed decisions possible.¹⁸ This entails considering at all points what evidence is available about the specific

medical condition at hand.¹⁹ Therefore, evidence-based knowledge is very much present in the clinical practice of the truly wise practitioner, guiding—but not controlling—his or her decisions at all points. We emphasize again that the guidelines are not the be-all and end-all of clinical practice. They are, after all, *guidelines*.

Finally, overemphasizing the importance of individualized patient care as superior to EBM ignores the extent to which similarities between individuals can be informative and useful. Parker writes, "If we overemphasize the unique and the particular, we can underestimate how much we are the same."²⁰ The wise practitioner does not deal only with patients as unique individuals, but is also constantly on the lookout for reliable trends for which useful and important evidence is already available. Thus, the wise practitioner has every reason to be standing on the shoulders of EBM giants, for to ignore such reliable evidence will invariably detract from the best clinical practices.

Moreover, dealing with medical issues on a case-by-case basis is complementary to EBM in its reliability and can itself be considered as EBM when it proceeds in an empirical, hypothesis-generating, and testing manner.²¹ For example, when reporting adverse events to the U.S. Food and Drug Administration, case reports that challenge, dechallenge, and rechallenge are vital and appropriately recognized for their evidentiary value.

Crucially, there is no need to frame human universals as more closely related to EBM and clinical wisdom as accounting for individual differences. There is an entire field of scientific, evidence-based, experimentally validated knowledge about differences in the minds of individuals: personality psychology (for example, Larsen and Buss²²). There is therefore no reason to relegate any aspect of the clinical encounter to a special, *sui generis* non-empirical realm.

IMPLICATIONS FOR EDUCATION

The authors recommend that we create course work specifically dedicated to clinical wisdom, that "senior, seasoned clinicians routinely come into the classroom and present cases

utilizing clinical wisdom as a scaffold for case analysis,” and that these clinicians teach skills such as “mindfulness” and “emotional agility.” Although medical education might benefit from the inclusion of more-experienced practitioners, we must take caution before advocating the kind of educational approaches suggested by Baum-Baicker and Sisti. We are all in favor of those with more knowledge teaching those with less, as this is the basis for all educational institutions. However, for reasons similar to those outlined above, practitioners who are in favor of clinical wisdom as somehow separate from or superior to EBM are unable to provide clear definitions of what exactly this “extraneous” of clinical wisdom is, inevitably reducing it to that dubious factor of “experience.” This is not an accurate or sufficient definition, as any argument for the superiority of a particular approach should clearly distinguish its qualities and effects. Without such a definition or transparent criteria, it is hard to know that reliable and useful knowledge is being transmitted. Baum-Baicker and Sisti themselves do little more in explaining the supposed source or “otherness” of clinical wisdom, reducing it always to that unattainable tenet (our emphases in italics): “most . . . understandings of wisdom include the desideratum of *experience* . . . what the talented senior clinician had gained through *decades of careful listening and practice*.” In fact—for what it is worth—there even exists research suggesting that experience itself may not be sufficient for wisdom, but that rather, certain kinds of knowledge must also be added at different stages of the individual’s development.²³ In many domains of human knowledge, from baseball scouts’ selecting the best player to policy wonks’ picking elections, expert opinion based on seniority and option is routinely debunked as being less reliable than expected, and often no better than chance (for example, Tetlock²⁴). Moreover, the idea that experience *per se* is associated with good clinical results has been called into question by other research findings that therapists’ levels of experience are unrelated to patients’ outcomes.²⁵

Although Baum-Baicker and Sisti are laudable in attempting to take a first step toward

describing what such experience-formed practices might be, the ultimate conclusions they reach are shaky because of the methodological and definitional reasons mentioned above. In fact, even if we ignore these reasonings, the fact that the interviewed practitioners are rated as wise by their peers does not necessarily form an irrefutable argument in favor of the kinds of educational additions proposed by the authors; Parker directs us to Goldner and Blisker: “Personal case observations and the inferences made from them are more prone to distortion due to small sample sizes, difficulties in ruling out confounding factors, the unsystematised nature of information collection, and the biases and interests of clinicians.”²⁶

As in the rest of psychological science, personal case observations are valuable in suggesting *a priori* hypotheses to test further, but are not in themselves constituted as veridical evidence. Thus, when asked to choose between the wisdom of individual experience and the wisdom of replicated, validated “crowds” of data that are EBM, we believe the choice is obvious. And lest we be seduced by personal experience that seeks to trump vetted evidence, let us note that even senior clinicians may develop bad habits that become deeply ingrained; one seriously bad habit is ignoring the available medical evidence. Nothing less than the safety of patients and efficacy are at stake, as our first priority should be to do no harm.

ON RULES AND BREAKING THEM

Of particular interest are those exceptional cases in which Baum-Baicker and Sisti find that wise practitioners depart from the standard rules. In such circumstances, it would appear especially important that these practitioners be able to justify and clearly explain their decisions relative to the available EBM. But further, if these rule sidesteppings truly *are* justified, such that they lead to the most ethical decisions, all things considered, then this fact should draw attention to a larger problem inherent in the systems that would seek to prevent such sidesteppings in the first place. That is to say, the need to bend a rule might indicate a significant

flaw with the current system and rules themselves. If this is the case, these systems should be tackled directly, rigorously, and empirically, rather than temporarily band-aided through the teaching of educational courses separately from, or in addition to, the standard medical knowledge, as proposed by Baum-Baicker and Sisti. After all, trainees might be confused by the mixed message of rule bending, in which the contradiction between teaching rules, as well as how to evade them, could blur an institution's overall educational mission: "Providers resort to bending the rules because they believe they have no other options. But they do. They should bring the problem up the chain of command. If the rule doesn't fit, then change the rule."²⁷ "More hopeful are people called 'system changers.' These are people who are looking not to dodge the system's rules and regulations, but to transform the system."²⁸

Even something as seemingly nebulous as "flexibility" can be incorporated into a rule by the wise rule maker. The best kinds of rules are not only pragmatic, but also encourage practices that increase virtuous behavior. Real-life examples of such systems include the Veteran's Court, in which cases involving veterans who have broken the law are treated individually and with dedicated attention, as opposed to being settled with the standard mandatory sentencing; for-profit law firms that encourage lawyers toward *pro bono* work for their low-income clients; and the Harvard medical training system, in which medical students spend an entire year working with a single patient, so as to learn genuine empathy for individual persons.²⁹ Furthermore, these systems have excellent success rates. The wisest practitioners do not try to teach newly discovered wisdoms separately from the traditional canon; rather, they refine or redefine current rules and systems already in place, to permanently incorporate these new wisdoms into medical systems and make them readily and reliably available to future generations.

Therefore, promoting selective rule bending as wise practice does not solve the fundamental problem that leads practitioners to waver from the rules in the first place, and is therefore neither healthy nor sustainable. It should be

noted that rules are not made to be broken, and that it should be only in the most exceptional cases that rule breaking becomes necessary. Experienced practitioners know when to bend the rules, precisely because they are well acquainted with the rules and regulations. The same cannot be said for novices. Novices, by definition, are not in a position to take such risks and should not have to. Indeed, novices often break rules accidentally because they are not familiar enough with them. We are not suggesting novices be prevented from receiving pedagogy regarding wise practice, but explicitly teaching novices how to bend the rules seems both irresponsible and risky. The first principle of medical ethics is to "do no harm," and we should be mindful of this as we consider that our treatments have powerful effects, both good and bad. Also, negative outcomes that can be directly tied to deviations from the standard of care can lead to lawsuits for negligence, sanctioning, limits on ability to practice, revoking of license, criminal charges in those cases in which the incident is reported, and a worsened relationship between practitioner and patient due to the practitioner's damaged reputation.³⁰

We also suspect that rule bending may seek to preserve medical professionalism as an art form, but that this is at the expense of our patients. Rules exist to ensure that practitioners make the best decisions when it comes to patient care. This may seem obvious, but the importance of rules can be confused and forgotten when subverted or replaced by more romantic views of virtuosity. For instance, one of the practitioners quoted by Baum-Baicker and Sisti opines: "I've decided what comes first is being decent for a therapist. If a person is basically decent then they'll use anything they know to help the patient. And if they don't have a basic decency, it doesn't matter what they know. Nobody's going to get help."

Although a capacity for kindness/decency is certainly a virtue that we should strive to incorporate into our healthcare philosophy, it does not alone, or even primarily, among other factors, guarantee that proper healthcare will be provided. We cannot expect people to do the right thing just because we have taught them

what that right thing is. This is a wishful view of human nature that underestimates the importance of third-party rules and other control systems to create peaceful, safe, and egalitarian societies.³¹ Human history is littered with catastrophes rooted in myopia and selfishness, such as the recent stock market collapse, which serve as alarming reminders that rules are needed to check our wayward tendencies and ensure functionality despite individual differences in characteristics such as decency. This is also a form of practical wisdom: principle-based rules have embedded in them instructions as to what should and should not be done in different situations, awareness of ambiguity, and the need for self-analysis in the course of application, and although it is unlikely that everyone in a system will be decent, everyone in a system is required to follow the rules. We can strive to make decency a *characteristic of* the rules that we decide on, as well as of how we interpret the inevitable ambiguity that exists in the course of the interpretation, application, and heuristically mindful practice of rules.

CONCLUSION

Attention must be given when forming distinctions among different kinds of knowledge, as these distinctions have far-reaching implications for medical and educational systems. In particular, we agree with Parker that the important difference in medical knowledge rests not, as Baum-Baicker and Sisti suggest, on the source of knowledge—which is poorly defined and misconstrues the practical and dynamic relationship between EBM and non-EBM knowledge—but on its *dependability* (including its reliability, internal and external validity, efficacy, and safety), clearly captured in the definitional difference between EBM and non-EBM knowledge. Understanding this subtle difference has far-reaching implications for how we research, practice, and teach clinical wisdom.

While we admire the spirit of Baum-Baicker and Sisti's suggestion to incorporate wisdom into residency training, we advocate for more rigorous theory and methods to underlie this venture. As the authors' introduction implies,

there is an extensive literature describing wisdom over time that could be used to more precisely iron out these variables, after which data could be collected, validated, and established as reliable before any conclusions are proclaimed as truth or physician training programs are altered. In addition, we believe that clinical wisdom should not be seen as "separate" or "other" from EBM, but rather that it be conceived of as complementing and enhancing the latter, and thus taught with a coordinated approach that integrates both EBM and non-EBM based knowledge at all points and recognizes uncertainty within each as well as the added value of each for even the wisest clinicians. Furthermore, we warn that the practice and teaching of rule bending is inherently inimical to any educational curriculum and is not consonant with the fundamental purposes of rules and their comprehension.

In sum, we propose a more sustainable solution that directly tackles these comprehension problems, flawed rules, and pseudocertainties by meliorating current systems in place while acknowledging the eminent complementarity of EBM and case-based knowledge in contributing to wisdom.

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NOTES

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10. Ibid., 275.

11. Ibid.

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17. Parker, see note 6 above, p. 277.

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25. L.E. Beutler, P.P.P. Machado, and S.A. Neufeldt, "Therapist Variables," in *Handbook of Psychotherapy and Behavior Change*, 4th ed., ed. A.E. Bergin and S.L. Garfield (Oxford, U.K.: Oxford, 1994), 229-69.

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27. Healthcare Providers Service Organization, "The Risks of Bending the Rules," (n.d.), <http://www.hpso.com/resources/article/54.jsp>, accessed 11 September 2011.

28. B. Schwartz, "Using Our Practical Wisdom," (TED), <http://www.youtube.com/watch?v=IDS-ieLCmS4>, accessed 11 September, 2011; R.L. Dickman, "Bending the rules to get a medication," *American Family Physician* 61, no. 5 (March 2000): 1563-4. The preferableness of system changers over rule dodgers is emphasized, for example, by Dickman, who presents a case scenario in which a doctor is forced to bend the rules to help a patient, consequently cheating an insurance company of its profits. Dickman concludes: "Finally, unless we as physicians take the lead in advocating for available health care for every American, painful decisions such as these will need to be made on an almost daily basis" (p. 2). In other words, a constant bending of the rules is only a temporary, unsustainable solution to a larger problem.

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30. Healthcare Providers, see note 27 above.

31. S. Pinker, *The Blank Slate* (New York: Penguin, 2002); S. Pinker, *The Better Angels of Our Nature* (New York: Viking, 2011).