Jodi Halpern, "Attending to Clinical Wisdom," *The Journal of Clinical Ethics* 23, no. 1 (Spring 2012): 41-6.

Attending to Clinical Wisdom

Jodi Halpern

ABSTRACT

In response to the article by Baum-Baicker and Sisti,[1] I will consider the kind of wisdom involved in therapeutic listening; the role of life wisdom; and the challenge of imparting clinical wisdom to young health professionals' education.

When I read an article like the one written by Baum-Baicker and Sisti, the first question I ask myself is why the authors are writing it now. This may be too psychoanalytic, but I presume that all action is to some degree a "defense" or, better said, a way of grappling with something anxiety provoking. This isn't to say people don't write for many other reasons as well, including an ecstatic urge to share highly valued experiences. This article demonstrates, I hypothesize, both ecstatic and defensive writing. The authors' enthusiasm to capture the words and ideas of revered, elder psychotherapists is self-evident throughout the article.

I found the anxiety behind the work on the 10th page. Baum-Baicker and Sisti are worried that behavioral health systems are replacing therapists with "providers." They quote William James's critique of professional philosophers, substituting "mainstream mental healthcare provider" for "professional philosopher." They are trying to capture the clinical wisdom that is increasingly at risk in this era of efficiency maximizing behavioral health systems.

What aspects of mental health systems devalue clinical wisdom? First, the emphasis is on standardization and accountability over creativity and individualizing treatment. Practitioners are expected to follow guidelines. In mental health, this can go so far as providing manuals to guide conversations with patients.

Second, as "behavioral healthcare" implies, the only things that count are "observable behaviors. " Thus, providers are expected to reliably "act" empathic, nodding, not interrupting, not looking at their watches. This reduces a complex cognitive-affective experience to a set of rote behaviors that can be learned quickly. This diminution of empathy skills is also motivated by cost-cutting. Managed health systems often hire younger providers who lag behind patients significantly in life experience. I think of a recent *New York Times* article, "Should a Life Coach Have a Life First?"[2] I agree with Baum-Baicker and Sisti that we need to preserve rich, empathic patient-caregiver relationships if we are to remain healers and not just patient managers. What wisdom can we glean from the experiences of wise psychotherapists for building such relationships?

The authors invoke the term *phronesis* to cover heterogeneous forms of practical knowledge in bioethics and clinical practice. Since we are learning from expert psychotherapists, it's useful to focus on phronesis and psycho-

Jodi Halpern, MD, PhD, is an Associate Professor of Bioethics in the Joint Medical Program and the School of Public Health at the University of California, Berkeley, *jhalpern@berkeley. edu.*

logical suffering. This sets aside other important questions regarding individualizing medical diagnoses and treatment recommendations. It also sets aside the nature of something like ethical wisdom for bioethicists. Still, responding appropriately to psychological suffering is a core part of medical, nursing, social work, and bioethics practices.

Let us thus consider two questions the expert psychotherapists shed light on: First, what kind of wisdom is involved in therapeutic listening? Second, what role does life wisdom play in clinical wisdom? Later I will briefly address the meta-questions: How might such wisdom inform broader healthcare practices—medicine, nursing, social work? How can such practices be taught?

CLINICAL WISDOM AND LISTENING

Therapeutic listening, or empathy, comes in many forms. Sometimes it involves understanding a patient cognitively, sometimes resonating affectively, and sometimes vividly imagining an experience from the "inside." Empathy skills integrate *knowing about* patients with *knowing how* to connect. Expert psychotherapists describe the importance of tolerating uncertainty, of staying open to new experiences with the patient. In almost two decades of studying clinical empathy, I find curiosity and openness are essential.[3] As one psychotherapist in this study noted, "If somebody knows where it's going in the therapeutic dyad, something's wrong."

The "Wisdom Project" interviews speak to two aspects of listening that are difficult to standardize. The first is the embodied know-how, nonverbal attunement, which intuitively guides clinicians about when to keep silent and when to inquire and interpret. The second is listening for the particulars, with the goal of vividly imagining how it feels to be this unique person, rather than trying to fit the details into diagnostic generalizations. Let's call this narrative listening.

The first element, nonverbal attunement, shows itself in comfortable silences, as well as in moments like this one described by psychiatrist Glen Gabbard. As Gabbard talked about his own impending vacation, his normally reserved adult patient began weeping. Gabbard was suddenly overwhelmed with a feeling of abandonment, which led him, without conscious thought, to say: "six year old sadness?" That was the age when his patient's father had left. Gabbard already knew this fact; the point here is that he had internalized it in his embodied imagining of her experience.[4]

In psychotherapy, embodied know-how and narrative listening are intertwined. Gabbard intuitively uses personal details gleaned from attentive listening. Resonance with another's mood provides stage lighting, and imagination fills in the picture with narrative details. Thus we can have a kind of waking daydream of the patient's world as if we were living in it. For example, a widowed patient moved in with her adult daughter and was having insomnia. I vividly imagined her sitting in the living room at night, reluctantly shutting off the television to lug herself, heavy with sadness and exhaustion, up to her stuffy attic room. Of course, the house scenes I imagined combined her narrative details with my own pre-existing experiences. The listener always makes use of her own mental contents. Rather, the point is that resonant moods integrate narrative details into a vivid as-if experience of a world, which is why empathy involves having an experience, and not just knowing something about another person.[5]

LIFE WISDOM AS A SOURCE OF CLINICAL WISDOM

The therapists describe the value of being pragmatic and kind, of having humility and balance. Let us call this "life wisdom." They give many examples of how life wisdom contributes to psychotherapy, including learning to tolerate silence and to time interpretations. Pragmatism and tolerating uncertainty contribute to openness and flexibility: "there is some consensus that the trademark of wisdom is in knowing how, where, and when to (1) take risks and (2) deal with uncertainty." I would add that taking risks wisely requires being mindful of clinical boundaries, a topic I touch on later.

Beyond contributing to individual sessions, life wisdom contributes to conducting a longitudinal therapy over time, and to enjoying one's

own work over decades. Pragmatism and humility go hand in hand, as with recognizing the transience of life. One of the "Wisdom Project" psychotherapists, Hedda Bolger, states: "I have many thoughts about the future, and I remember the past with both joy and sadness, but without nostalgia. I am grateful for being able to live in the present with what feels like an appropriate mixture of awe and despair, of hope and dread."

Combining pragmatism with humor and playfulness protects against burn-out. One participant in the "Wisdom Project" notes that you "can't work with a teenager unless you find teenage hostility funny." Another says, "there has to be room for play and playfulness. . . . Life isn't all plodding . . . you can have levity even though you're dealing with very serious stuff. " Another describes how pragmatism, humility, balance, and humor all contribute to sustaining clinical empathy and compassion, and vice versa: "It takes, finally, over many, many decades, developing a kind of caring and compassion for this person . . . and what he's been through . . . and to respect the stuck points, to respect what he can't do, and not to shame him in terms of your goals. It's a humility and a caring for this particular soul and this particular circumstance and to see what will yield. What the circumstance can give you, what this particular person can give him or herself, and you can't rush it."

This brings to mind the "serenity prayer"[7] from popular culture. Therapists and other clinicians need to accept what they can't change, have courage to change what they can, and have the wisdom to know the difference. Thus let's refer to the life wisdom that leads to clinical humility as "serenity skills." Clinicians need both empathy skills and serenity skills. While the two are often intertwined, serenity skills add something; they help clinicians enjoy and derive meaning from their professional lives through hard times, thus reducing burn-out.[6]

IMPLICATIONS FOR HEALTHCARE EDUCATION

The capacity to listen empathically, to imagine the patient's world, is crucial for medical, nursing, and social work practices. Patricia Benner, a leading healthcare theorist, has demonstrated the therapeutic power of not only listening to, but taking actions to meet, patients' "subjective" needs. One nurse helped a depressed hospitalized patient regain the will to live by finding a way for him to play a piano. Another patiently assisted a middle-aged man who had a stroke and was partially paralyzed to take his own shower rather than efficiently sponge-bath him. Recognizing each person's "situated possibilities" is empathy in action.[7]

How do we teach clinical wisdom? Can we observe and outline what experts do in terms of rules, however complex, that would allow us to create manuals or algorithms for these skills? This question is a particular version of a more general, unresolved set of philosophical questions about phronesis. Is practical wisdom the same as deliberative reasoning but the reasoning is unconscious, or is it like perceiving an object as beautiful, something no rules can tell us how to do?

Hubert Dreyfus argues that expert know-how is ultimately irreducible to a set of rules; the importance of rules is in teaching novices a new practice. He uses the analogy of a bicycle with training wheels, which help us learn to ride, but once we are skillful, we don't ride as if our bikes still had invisible training wheels. We innovate in ways that training wheels would hinder. Empathy and serenity skills are forms of know-how. *Knowing how* is not necessarily reducible to *knowing that*. Bertrand Russell famously distinguished experiential knowing, knowledge by acquaintance (knowing a person), from knowledge by description (knowing that).[8] When descriptive knowledge is inadequate, we turn to more experiential forms of education, including mentorship, story telling and art, and transformative practices.

What then does this mean for clinical education? Just as training wheels help a person learn to ride a bike, experts can teach rules of thumb (not laws) for being a good listener. Working with new medical and nursing students, I suggest rules of thumb such as, avoid saying "I know how you feel. " Better to say, "I wonder if it's like . . . " or just repeat an emotionally laden word or phrase and pause. When you sense a

gap in communication, feel free to ask, "Tell me what I'm missing. " Try not to comment or ask a question when you are angry. A question like "Why don't you take your medication?" is much more effective when you calm down and are genuinely curious rather than annoyed.

Rules of thumb contribute to even such nonconceptual practices as dancing. Listen to the beat, keep the appropriate distance (this varies enormously from tango to rock and roll), if you make a mistake, just keep going. Still, we need to see people dance to truly learn how to move.

Rules also play an important part in helping clinicians understand that their profession is guided by, even made possible by, boundaries. I teach residents boundaries by explaining why I can't meet my patients in a coffee shop—I can't be a therapist there. It's not the office *per se*, but the scaffolding the profession provides—a promise to the public that patients will be treated with respect and not exploited, that their privacy will be guarded, and so on. Both the patient and I operate together within that framework—the framework is not an idea in my head to be creatively rearranged. So to add to Dreyfus's metaphor, expert bicycle riders still should follow the rules of the road.

Still, learning rules of thumb and rules of the road is not sufficient to develop empathy and serenity skills. What else helps? Watching empathic clinicians listen to their patients is valuable. Medical and nursing educators can do this more easily than psychotherapists, given the limitations of privacy. We can watch each other's daily rounds. A national nursing study demonstrates how modeling powerfully influences novices to develop interpersonal skills.[9]

What about wisdom coming with age? Note that these elder psychotherapists say it took them decades to gain such wisdom. How do we help young clinicians become wise earlier than they might otherwise? This raises questions about psychosocial maturation. While surgical expertise can perhaps be hastened by exposure to high clinical volume, emotional maturation cannot be accelerated this way.

What can young medical and nursing students do? Read patients' narratives. Rita Charon has demonstrated the power of learning to write patient-centered narratives for developing demonstrable clinical empathy.[10] In addition to gathering the narratives of their hospitalized patients, students would learn even more if they were to provide longitudinal care for chronically ill patients and their families during the entirety of medical or nursing school. This is feasible; Case-Western Medical School used to offer a longitudinal care experience, beginning the first year of medical school, following a pregnant woman. The point is that we can learn the most directly from patients. Recently I've had the opportunity to interview people living well with chronic illness and/or disability. A quadriplegic woman who founded a dance company, a physician with breast cancer who left her stressful career to pursue art, a social worker with Parkinson's disease who uses humor and compassion to help resolve family conflicts, have all taught me lessons about living wisely.

Many of those I interviewed were older than me and had life challenges I never faced. This speaks to the possibility of very young medical and nursing students empathically connecting with middle-aged and older patients. By approaching patients with genuine empathic curiosity and humility, young students may connect deeply with them and learn a great deal about the human condition. The barrier to this is that medical centers often ignore older, more disabled patients who are not candidates for exciting medical interventions. To counteract this, a great clinical teacher, Sheldon Margen, used to hold weekly "stroke" rounds during his rotations at the University of California, San Francisco (UCSF) Medical Center.[11] On Fridays medical students were expected to interview the elder stroke patients, focusing on life experiences rather than on medical histories. Students were deeply moved by what they learned from people they had previously ignored.

Many students gain wisdom about illness experiences though the arts. Some medical and nursing schools include this as part of the curriculum. At the University of California, Berkeley-UCSF Joint Medical Program, where I teach, students and retirement home residents write and perform plays together.[12] Many students describe this as their most valuable learning

experience in medical school. Poetry is especially apt in addressing the paradoxical nature of clinical wisdom. Baum-Baicker and Sisti include a wonderful list of statements from the study participants, each like a Zen koan. Consider: "We know and we don't know; we listen with a knowing confusion, keeping and throwing out all that we learned during out training." Or "We're attached and we're separate." "Psychotherapy requires acceptance of the patient while simultaneously working towards change." What strikes me is how even expert psychotherapists' "descriptions" of the affective aspects of listening to patients are not really descriptions of matters of fact, but are poetic expressions: "I dive into the patient, I let their feelings wash over me." Or, "allow yourself to flow into their embeddedness."[13]

Art and music therapists are especially skilled at helping people develop empathy. Martha Snider, a physician who is also an artist and a writer, teaches clinicians to use art to express emotions that are difficult to put into words. "A painting with seared edges or dripping reds shows rather than tells how the loss felt. " When she had breast cancer, she painted breasts with bright, angry red over the area of the cancer, conveying feelings before she was even consciously aware of them.[14]

What about learning skills to tolerate, and, ultimately, make clinical use of, difficult emotions? Baum-Baicker and Sisti suggest mindfulness training, and I agree; there is evidence that mindfulness improves clinical care and professional satisfaction.[15] Meditation practices can also specifically target developing self-compassion, which anecdotal evidence suggests improves compassion for others (an active area of research).[16] The wise psychotherapists urge clinicians to learn "to forgive themselves for the errors they made or the things they didn't do, or did do. "

Yet in contrast to mindfulness practices, which seek to dissolve thought about the particulars of experience, psychotherapists dwell in the particulars of their patients' lives. Just yesterday, a talented song writer spoke about how the goals of mediation are not enough for empathic communication. She said, "when I meditate, I let go of the past. But to write songs which make emotional connections with other people, I need to immerse myself in real experiences in all their details, and that means reaching into my past."[17] Note that I am not presuming busy doctors and nurses need to dwell in their own or their patient's past histories. However, "the past is never dead, it's not even past."[18] Empathy includes being curious about how patients' responses to illness and disability are conditioned by past experiences.

Mindfulness is good, but even better would be to help clinicians develop self-empathy, an attitude combining self-compassion with ongoing curiosity about the emotional particulars of daily life. Not only is self-empathy a promoter of empathy for others, it may also decrease the risk of burn-out. Burn-out is associated with lack of self-care,[19] and young people who go into healthcare professions often are other-focused and may not know how to care for themselves. The best process I know for gaining self-empathy is psychotherapy. Perhaps we ought to help medical, nursing, and social work students gain access to psychotherapy during clinical training. Years ago, when I was a psychiatry resident, my cohort started a program at University of California, Los Angeles, where expert psychotherapists offered residents free psychotherapy (they got teaching credits at the UCLA Medical Center). In addition, we engaged in longitudinal peer support groups on a weekly basis for all four years of training. Thus, we regularly shared our challenging experiences as residents. We watched each other change and mature emotionally in rich, unanticipated ways, at a different pace than was occurring before therapy. This caused some upheavals—a divorce in one case and, in another, a decision to leave medicine for a career in the arts. Given the intensity of small group dynamics, such groups are only advisable when there is excellent group leadership, and a willing and responsible peer group.

Despite carrying some risks, the combination of individual psychotherapy and a professional process group provided young residents an intensive, en-wizening experience. Despite bumps in the road, we learned to speak with

each other about our concerns and insecurities without shaming each other. Some hadn't really received empathic listening in their lives until they were in therapy, and I believe that it is almost impossible to truly empathize with others until you have been empathized with yourself. The trust we developed with each other also inculcated in us a lifelong habit of reaching out to other clinicians for consultation and support, something that doctors, at least, are notoriously uncomfortable doing. I believe that this has contributed to the fact that almost 20 years later, each of us loves our work and shows no sign of burning out. It would make a huge difference in healthcare if group practices fostered self-empathy, trust, and mutual support among the practitioners.

Let me conclude with a radical suggestion connecting clinical wisdom to love. If we recall Plato's account of education as based in *eros*, learning involves love. Speaking for myself and colleagues, our own psychotherapeutic experiences during residency have been deeply internalized, helping us live our professional and personal life more fully. It is difficult to imagine how any behavioral medicine course could have had such profound and persisting influence. What I found most moving about the participants in the "Wisdom Project" is that these octo-, nono-, and centagenerian psychotherapists continue to attend their peer supervision groups and present their cases to each other. They truly love their work.

ACKNOWLEDGMENT

Thank you to Norman Quist, whose editorial wisdom and inspiring ideas contributed significantly to this essay.

NOTES

1. C. Baum-Baicker and D.A. Sisti, "Clinical Wisdom in Psychoanalysis and Psychodynamic Psychotherapy: A Philosophical and Qualitative Analysis," in this issue of *JCE*.

2. S. Morgan, "Should a Life Coach Have a Life First?" *New York Times*, 27 January 2012.

3. J. Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (New York: Oxford University Press, 2011).

4. G.O. Gabbard, "Disguise or Consent: Problems and Recommendations Concerning the Publication and Presentation of Clinical Material," *International Journal of Psychoanalysis* 81, no. 6 (2000): 1071-86.

5. Halpern, see note 3 above.

6. T.D. Shanafelt et al., "Relationship between increased personal well-being and enhanced empathy among internal medicine residents," *Journal of General Internal Medicine* 7 (2005): 559-64.

7. P. Benner, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (Menlo Park, Calif.: Addison-Wesley, 1984); P. Benner, *The Primacy of Caring: Stress and Coping in Health and Illness* (Menlo Park, Calif.: Addison-Wesley, 1989).

8. "I know it when I see it." B. Russell, "Knowledge by Acquaintance and Knowledge by Description," *Proceedings of the Aristotelian Society* (New Series) XI (1910-1911): 108-28.

9. P. Benner, M. Sutphen, V. Leonard, and L. Day, *Educating Nurses: A Call for Radical Transformation* (New York: Jossey-Bass/Carnegie Foundation for the Advancement of Teaching, 2009.)

10. S. Dasgupta and R. Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," *Academic Medicine* 79, no. 4 (April 2004): 351-6.

11. Sheldon Margen, personal communication.

12. Guy Micco created and teaches this medical humanities course.

13. This is not meant to imply we can't study psychotherapy empirically, as, for example, Lester Luborsky and Mardi Horowitz and more recent researchers have. We can study affective states, we can study the therapeutic alliance, and we can certainly study clinical outcomes.

14. Snider is creating a book of writing, photographs, and paintings.

15. R. Epstein, "Mindful Practice," *Journal of the American Medical Association* 282, no. 9 (1999): 833-9.

16. K. Neff, S. Rude, and K. Kirkpatrick, "An Examination of Self-Compassion in Relation to Positive Psychological Functioning and Personality Traits," *Journal of Research in Personality* 41, no. 4 (2007): 908-16.

17. Marie Schumacher, personal communication.

18. William Faulkner, *Requiem for a Nun* (New York: Vintage, 1951, 1975).

19. M.K. Kearny, "Self-Care of Physicians Caring for Patients at the End of Life," *Journal of the American Medical Association* 301, 11 (2009): 1155-64.