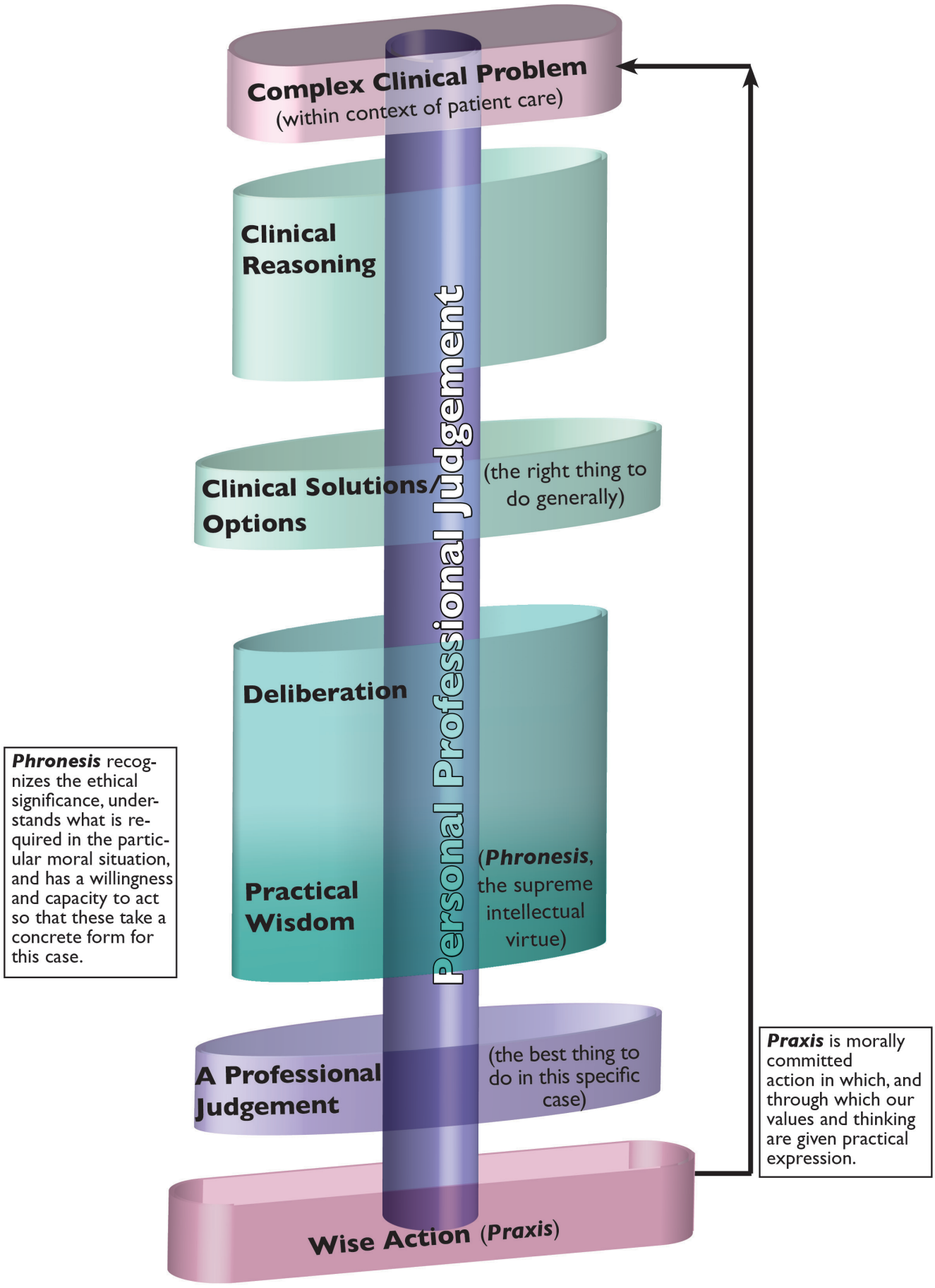
Paper 21

Phronesis & Asklepion in Medicine

The Clinical Thinking Pathway (CTP) and the Influences during treatment



An Aristotelian classification of Forms of Reasoning

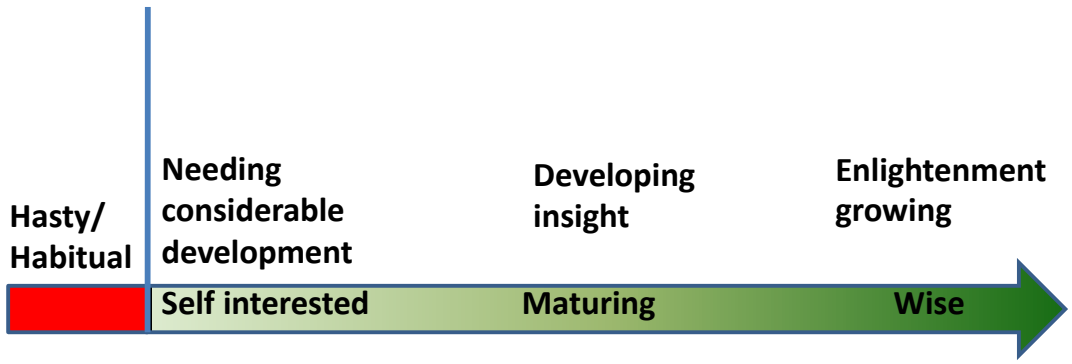
(Adapted from Carr, W. 2009: 60)

Form of reasoning	Theoretical	Technical	Practical
Disposition	***Episteme*** The disposition to seek knowledge for its own sake	***Techné*** The disposition to act in a rule-governed way to make a pre-planned artifact	***Phronesis*** The disposition to act wisely or prudently in a specific situation
Aim ***(telos)***	**To seek truth for its own sake…** Seeking to achieve eternal and pure truth	**To produce some object or artifact (like a chair or a house or some thing a craftsperson has made to a *preconceived design*).** This would produce craft, but not art	**To do what is ethically right and proper in a *particular*, practical situation.** The basis of art which includes craft
Form of action	***Theoria:* contemplative action**	***Poesis:* Instrumental action that requires mastery** of the knowledge, methods and skills that together constitute technical expertise	***Praxis:* morally committed action** in which, and through which, our values are given practical expression
Form of knowing	**Philosophy or abstract reasoning**	**Applied knowing or technical reasoning** (Greek craftsmen and artisans applied their knowledge — the principles, procedures and operational methods — to achieve their **pre-determined outcome)**	**Knowledge-inuse or practical reasoning** (For example: clinical reasoning; professional judgement; going beyond protocols — in relation to a specific case)

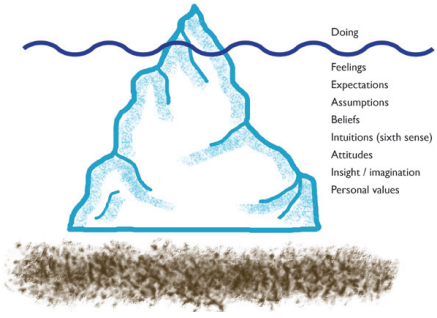
Some explanation of the quality of the different forms of Professional Judgement

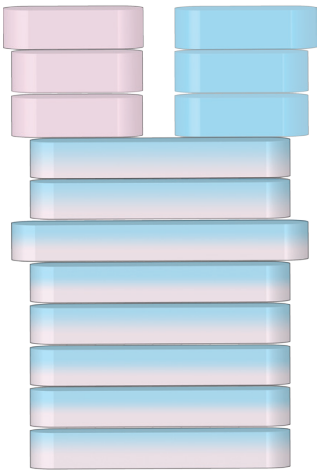
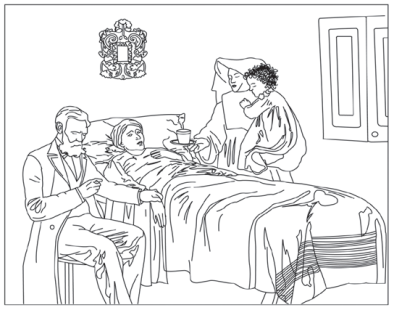
Kind of professional judgement (leading to:)	**Response to patient case**	**Motivation** (where the doctor places self in relation to managing the patient)	**Questions learner asked themselves**
Wise Judgement (enlightenment growing)	Sees each case as needing to be enquired into beyond the obvious, defines what is needed for the best for the patient, can do / obtain what is needed, (checks with senior as appropriate), then does it. Can make rational sense out of intuitive judgement and use pathway both ways up Treats all judgements as potentially provisional and requiring revisiting	Willing and able to put patient's interests first at all times in decision making, even if this risks own interests and position in some way	How can I achieve what is best for the patient? What else should be deliberated upon? Who else should I talk to beyond the obvious team?
Maturing Judgement (developing insight)	Open minded to the complexity of each case; builds on experience. Has a proper respect for conservative management but beginning to balance safety of patient with carefully judged risks	Beginning to put patient first in decision making but still lacks experience to step outside own needs in favour of patient's interests Beginning to see that you can play it too safe	What should I take into account here? Should I discuss this with my senior?
Self-interested Judgement (need for considerable developmental work)	Selects tactics known to please; closed minded about choices. Chooses what fits limited experience rather than seeing the wider context	Choice of decisions and resultant behaviour designed to enhance own performance and achievements in eyes of consultant	What would my seniors do and how can I please them? What am I personally able do in this case, and how will I do that?
Hasty / Habitual Judgement (recognition that this is unsatisfactory)	Knee jerk reaction / Going through the motions unthinkingly.	Has not even considered that choices are available.	None I've seen this before, haven't I? Why shouldn't I do the same again?

Quality of the judgement for each particular patient

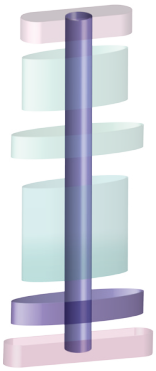
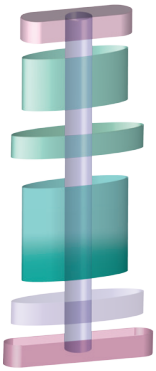


The Narrative Invisibles

The Invisible	Heuristic	Reflective Focus
Context	 **Woman under Willows**	The importance of the context of the case or event and the **interpretations made about it** cannot be overstated.
Kind of person you are	 **Iceberg**	This is about one's **personal values / assumptions / beliefs** as related to the case or event.
Kind of professional you are	 **Extended / Restricted**	This is about exploring **one's professionalism** in relation to the case or event.

The Invisible	Heuristic	Reflective Focus
14 Forms of Knowledge	 **Knowledge Cards**	This is the **range** and **kinds of knowledge** one brings to the case.
The Therapeutic Relationship	 **Doctor with Patient**	This shows the **quality of the relationship created between doctor and the patient.**
Contextual awareness	 **Faded out background**	This involves **seeing beyond the case** and all that is going on in its background and the wider global context of practice.

The Exploratory Invisibles

The Invisible	Heuristic	Reflective Focus
Professional Judgement	 **CTP 1 Decisions to Act**	This is the **quality of professional judgement** both *personal* and *product* one brings to a case.
Clinical Decision-making	 **CTP 2 Thinking processes underlying the decision to act**	This is the complex pathway of **one's clinical reasoning and deliberation.**

Rainbow Writing Colours

The colours now used in this process are:

BLACK **the bullet points outlining your case**

The Narrative Colours

Blue 1 **the CONTEXT of this particular case**
Blue 2 **the KIND OF PERSON you brought to the case**
Green **the PROFESSIONALISM you brought to the case**
Red **the FORMS OF KNOWLEDGE you brought to the case**
Pink **the THERAPEUTIC RELATIONSHIP with the patient**
Turquoise **WIDER CONTEXTUAL AWARENESS in the case**

The Exploratory Colours

Brown **Professional Judgement**
Purple **Clinical Reasoning and Deliberation**

Creating the Doctor-centred Narrative (Chapter Six)

A 49-year-old female librarian was referred to me because of a persistent discharge from her left ear. The history that I elicited from the patient was that she had no hearing in her right ear since birth and had recent problems with persistent discharge from her left ear.

Clinical examination revealed granulomatous disease in a tympanic membrane retraction pocket on the left side. There was no ear canal present on the right side. I sensed her anxiety and reassured her that I would do my best to relieve her problem. I explained that this would involve investigations and the possibility of an operation. I explained my suspicions to her and suggested that the next step would be to order a CT scan.

The patient was referred for a CT scan and the report indicated the presence of cholesteatoma. I reviewed the scan for myself before seeing the patient in clinic.

At the clinic following the scan, I explained to the patient the findings of the scan; namely disease in the left ear (which had poor levels of hearing), but was the patient's only hearing ear. I also explained about cholesteatomatous disease, and the possible outcome, over time, if the disease was left. I gave her the opportunity of asking any questions.

I then discussed the operation for this disease and the risks associated with the surgery (operating on the left ear could leave the patient totally deaf). The complications from surgery are very similar to the risks of leaving the disease but that by operating I hoped to minimise the risk of a complication occurring. She appeared unphased by this idea and showed some relief that something could be done. I was concerned however that she had not understood the possibility of complications.

She was anxious to go ahead with surgery, despite the risk of ending up totally deaf and appeared more concerned about getting back to work than she was about the consequences of a sudden operative complication occurring. Despite hearing complications / risks of surgery she just wanted to get on with the operation and was resigned to the fact that complications occur. Given the patient's reaction, I assumed she had not appreciated what impact a surgical complication would have, in particular the impact that total loss of hearing would have on her life. I had provided the patient with detailed information and believed that she would have been unable to process all this information immediately. I was concerned that once the patient heard about the risk of meningitis / brain abscess (which can occur, though rarely, with this condition) she had focused on this and was not giving any consideration to the other possible complications.

I also explained that one of the relative contraindications to surgery on the ear is operating on the patient's 'only hearing ear'. I explained to the patient that though I accepted her expressed desire to have surgery, that I, as her surgeon, wished to ensure that I had reviewed / considered all aspects of her complicated case before proceeding. I explained that I therefore wanted to discuss her case with my colleagues. Initially the patient seemed to be very much of the opinion that I 'knew best', but I was not so convinced. I had a limited experience as a relatively new consultant. I recognised that different surgeons would hold different opinions about whether to proceed with surgery on the left ear or not. I was concerned that my gut instinct, to operate on the patient's left ear, may not have been the opinion held by more experienced surgeons, and I wished to discuss the case with them, to reassure myself that I was doing the right thing for this patient. I had also seen the patient in the middle of a busy clinic, which had been delayed due to an earlier emergency, and was concerned that perhaps circumstances had influenced how I had imparted the information to her. Perhaps the subconscious pressure of needing to finish clinic before the afternoon consultant arrived or just a lack of clarity of thought from a time-pressured clinic had influenced how I had expressed myself on that day. I also wanted to ensure that the patient had fully considered the gravity of the situation. Before she left, I gave the patient an information leaflet about the ear disease, the surgery for this condition and its associated risks. I assumed the patient was concerned enough about her condition that she would read the information leaflet and I hoped that would clarify any issues I had not fully addressed. That way I could have a more informed discussion with the patient at her next outpatient appointment.

Though not entirey unheard of, this was the first time, as a consultant I had come across this type of case (cholesteatomatous disease in an only hearing ear). I also believed that the patient would accept 'the facts' as presented by me and would go with any decision I made. I was concerned that my initial thought (to operate on the left ear, in an attempt to preserve the patient's remaining hearing) might not have been the general consensus opinion held amongst a group of surgeons. I was anxious to do the best by my patient. I was also aware that in the event of a complication occurring and a medico-legal case arising, I wished to be certain that my decision to operate would be considered the most appropriate management for that patient. I wished to be certain that I was doing 'what was right' both for my patient and for myself (a new consultant who had a reputation to build).

I discussed with one of my colleagues about proceeding with surgery on the left ear, and with another colleague about what options were available for the patient if she did go deaf in the left ear after surgery. He first informed me he too would proceed with surgery in the left ear first, but stated that he was not sure if other ENT colleagues elsewhere would do the same. I discussed with another colleague, in another hospital, about what options for hearing rehabilitation were available for the patient if she did go deaf in the left ear after surgery. I was still

concerned the patient did not have a realistic grasp of what being totally deaf would be like. I was anxious to explore, prior to proceeding with surgery, future options of providing a hearing aid (in the form of a specialist implanted hearing aid) to the patient, should the need arise. Having discussed this case with two of my colleagues, I felt confident that proceeding with surgery was the correct clinical decision in this patient's case. I also felt reassured that I had considered and explored all appropriate options when making this professional decision. I wonder how I would have felt about operating had I found out that post-operative hearing rehabilitation would not be available / appropriate for this patient.

I then met the patient again in outpatients' department. We had a detailed discussion and I felt, on this occasion, that the patient had in fact considered her options in detail. I made the decision to proceed with the operation, in keeping with the patient's wishes.

During the operation on the left ear I removed the disease from most of the middle ear cavity but was left with the dilemma about removing the pocket over the stapes (the third hearing bone). I left the pocket undisturbed. Removal of this pocket greatly increased the risk to the patient's hearing. Not removing it potentially increased the risk of recurrence of the disease. I left the pocket undisturbed. I did not wish to unduly increase the risk to the patient's hearing. My decision not to operate on that part of the ear was, in my opinion, a considered one. I based my decision partly on my sense of duty to my patient not to put her at undue risk, as there was no disease in that part of the ear at the time of surgery. I also believed that despite our discussions prior to surgery, neither the patient nor I could truly appreciate what impact it would have on her life if the patient were to be rendered totally deaf at the age of 49yrs. I thought that I would find that an extremely difficult situation and assumed finding herself totally deaf all of a sudden would have a similar impact on my patient also.

One month post-operatively, the patient is recovering well from her surgery.