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THREE PATIENTS, TWO APPROACHES TO ILLNESS, AND A QUESTION: THE DNA OF CLINICAL WISDOM

Dave Davis
Family and Community Medicine, University of Toronto, Toronto, Ontario, Canada
drdavedavis@gmail.com

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There seem to be as many definitions of wisdom as there are examples—from the religious, to the linguistic, to the scientific and academic. In semiotics, the study of signs and their meaning, Baskara and Korionos[1] propose a hierarchy in which wisdom sits atop a pyramid of data, information and knowledge, each layer analyzed, ordered and incorporated into the next. From a clinical perspective (mine at least), the construct of clinical wisdom is recognizable but ill-defined, a cloth woven from the threads of experience, metacognition and perspective. The construct comes alive in its examples. I offer here observations from my own decades-long clinical and educational career, using a vehicle containing three patient stories, two reflections on the care of the whole person, and a question.

Let's start with the patients. After all, who are we without them?

Brad was in his late twenties when I first met him, early into my small, suburban family practice. Recently married with a newborn child and a brand-new home, he complained of lost interest in his job, his hobbies (he was an avid golfer) and, most sadly, his family. A tiny, overconfident psychotherapist lived inside me in those days, suppressed by a medical teaching system that favored the biomedical over the psychosocial. I pounced on an obvious diagnosis: “Reactive depression”, the little therapist said, blinkering me to other possibilities. After all, he’d undergone several stressful life changes in a little over a year. I suggested counselling, and, after a couple of sessions in which talk therapy was ineffective, an antidepressant. Six weeks later, the tricyclic (some readers may remember their unhelpful side effect profile) failed to work; if anything, his depression had deepened. Though not suicidal, he was clearly in need of more than my early-career skills. On his way out the door at our last session, he mentioned casually, “Jesus, doctor, I keep meaning to tell you: I am *so* constipated!”

I can’t tell you how often that doorknob elicited an important revelation.

“The antidepressants can do that,” I offered, but his answer set me back: “Oh no doctor, this was weeks before I started on them.”

The penny dropped, along with my heart.

My inner psychotherapist had blinkered me: I’d forgotten or ignored the evidence that GI cancers and depression are cousins. Frequently enough, they present together. A barium enema confirmed my fear. Brad had a particularly aggressive colorectal adenocarcinoma with metastases. The weeks’-long delay in his diagnosis had given the malignancy a head start. To this day, I remember my heart pounding and my face flushing as I read the X-ray report – the stigmata of guilt, the beginning of a kind of clinical wisdom. Strangely, the feelings of guilt or culpability, my most enduring teachers, were never once mentioned in my undergraduate or postgrad training. Mistakes? Medical error? They were never discussed.

Within the year, we lost Brad, one week shy of his thirtieth birthday and a month before the birth of his second child. Gone with him? The overconfident, psychotherapeutically-focused general practitioner. I re-doubled my focus on the biomedical. I became interested in teaching as a way to upgrade my own skills. I studied and became certified in family medicine, a relatively new training option at the time.

And then I met Deborah.

It was a few years after Brad's death; spring, the local river flooding its banks. Deb was in her fifties when I discharged her from hospital, recovering from an abdominal hysterectomy, the solution to fibroids and intermittent menorrhagia. She pointed to an area where the incision had broken down. I organized homecare and topical management for the minor infection, reassured her and signed her discharge.

Deb may have had a relatively uncomplicated hysterectomy, but she'd had a complicated year—her husband of two-plus decades had announced an extramarital affair, moved out of the house temporarily, and was now back home. The couple was in therapy. I'd like to think that I asked, "How are things at home, Deb?" but I am unsure. I'd like to think I got an upbeat response—perhaps, "Things are great, doctor. We're communicating much better, and I think we're back on track!"—but the years and my memory blur the conversation. What do I remember clearly? How much her hand shook as she pointed to the tiny infection in her surgical wound. How she couldn't look me in the eye. How, in the midst of a busy practice, I didn't explore the question, or even think, of the risk of self-harm.

Within hours, she was dead.

In a call from the emergency department later that afternoon, I learned she took a cab home and asked the driver to drop her at a bridge overlooking the swollen river. She could walk home from there, she told him. Horrified, the cabby reported what he saw in his rear-view mirror as he drove away: she ran to the low bridge railing, climbed over and jumped. He tried to save her, but failed, succeeding only in triggering an emergency response and a frantic, failing attempt to drag her from the river and resuscitate her.

What had I missed? The shaking hand when she pointed out the infection? The tell of her not making eye contact? I cannot imagine a pain that could push her to end her life. I can still unearth mine and observe it, a tiny sliver of hers, years later. Pain, a cousin of guilt, is also a gifted teacher.

And then, decades later still, when I had become a professor of family medicine, a kind of docent to other learners much younger than I, came a third wisdom-builder.

Meet Roger.

He was in his late seventies, most recently a high-end executive, now retired. Handsome, well-dressed (even in retirement he wore ties, each one costing more than an upscale dinner). Used to being in charge of things, he was bored. On the advice of his pastor, he decided to volunteer in a homeless men's program,

and was registering drop-ins when one of the clients grabbed Roger's wrist. "Stop writing my name down! You can't record me being here!" the man shouted at my patient. "The FBI will know!"

Roger did as he was told, and the man loosened his grip on my patient's wrist. The pain persisted however, burning and deep, sleep-robbing. Later that week, I examined him but could find nothing serious—no bruising, no restriction of motion; at most, only moderate tenderness. My biomedical antennae were vibrating as I was reviewing the case with a medical student: was this a scaphoid fracture in an older man, at risk for osteoporosis? Tendinitis, myofascial strain? An arthritic flare? A week later however, after the X-ray and tests revealed nothing and the pain appeared to worsen, my student suggested an MRI. Now a wiser (and much older) family doctor, I offered a different approach. I pulled a chair closer to our patient and asked, "Does this pain remind you of anything, Roger?" I'd like to think it was the voice of my teachers, Brad and Deb, who inspired the question. "Remember us: we are whole patients", they might have said.

To our great surprise, the face of this particular patient, the handsome, in-control, well-dressed former executive, crumbled.

In tears, Roger revealed that his stepfather had molested him decades before, grabbing his wrist, forcing his pre-teen hand to the older man's genitals—and then demanding more. Later, his psychiatrist (thank God for caring and competent geriatric psychiatrists) and I were to learn how much more—details buried in his subsequent years of study, work and ambition. What followed was a layer-by-layer revelation of the anguish of child abuse, months of therapy and finally, thankfully, healing. The pain in Roger's wrist? It disappeared, never to return.

What thread holds the beads of these disparate stories, strung over decades, together?

If it wasn't clear before, the voices of patients confirm what we know about whole person care: we fail a patient if we only consider one side of the biomedical-psychosocial divide, an artificial separation if there ever was one. And this becomes clear too: if there is wisdom in clinical care, it's the consideration of these as one entity, not two, not unlike the strands of DNA that create us, doctors and patients, in the first place. At least from my perspective, their connectedness, interplay, and development describe the arc of a career, the evolution of clinical wisdom across a long clinical journey, milestones on a journey to a wiser—I cannot say wise—physician.

Wisdom requires more of us however: like the science of quality improvement, it also requires an insistent, unrelenting questioning. Quality improvement professionals ask the question, why? at each step in an

investigation of medical error, repeatedly examining an issue and learning from it, a kind of forced metacognition. In the process, we must attend to those things that act as bridges between the patient and the clinician-learner—guilt and its cousin pain in my case, now more memory than feeling; truly listening to the voice of the patient; and the ability of the clinician to ingest and use the error messages.

Finally, it brings this question to mind, intended to probe the possibility that the journey to wisdom in medical practice may be shortened, that patients may be better aided in their journeys: is clinical wisdom teachable?

My patients and I would agree on one thing: we hope so. ■

REFERENCE

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Biographical note

Dave Davis, MD, is professor emeritus, family and community medicine, and former dean, continuing education at the University of Toronto. An educator and researcher, he is cited most frequently for his work in continuing medical education, physician competency and quality improvement. Dave is also a creative writer: patient stories and their lessons, altered and anonymized, fill his novels, newspaper commentaries and short stories. Visit https://www.drdavedavis.com.