Practical Wisdom in Action

By Adina Luba Kalet, MD, MPH

This past Sunday, Fred* became acutely disoriented, physically agitated, and distressed, likely as a consequence of another antibiotic-resistant urinary tract infection. Over the course of his 89 years, Fred has been an accomplished novelist, creator of children's books, a Korean War veteran, a rabid baseball fan, and a chocaholic. The past couple of years, though, have brought changes for Fred and his wife, Josephine; as his memory faded, they have been increasingly confined to their apartment. That said, they have continued to enjoy their time together, often sharing good food, classic movies, and reruns of old baseball games.

Their apartment is just a few blocks from the public hospital, his medical home. Fred is smitten with his brilliant and caring geriatrician, Dr. Lee. Under normal circumstances, when he gets sick, Fred and Josephine would call her, and she would meet them in the emergency room for lab tests, antibiotics, and a liter or two of IV fluids. A visiting nurse would stop by the apartment a couple of days later to provide an assessment and collect a urine sample.

But these are not normal times and Fred lives in New York City.

On the weekend Fred fell ill, physicians and nurses' phones were being diverted to call centers, and all of the emergency rooms were jammed. There weren't enough healthy visiting nurses to cover homecare duties. A trip to the ER would mean a long, lonely wait for Fred, separation from Josephine, and exposure to people with COVID-19. If Fred is septic, he would be hospitalized. If his breathing deteriorated, the treating team would have to decide whether to intubate him and place him on a ventilator. During a citywide scarcity of ventilators, supporting Fred in an ICU might not be seen as a priority. The faculty and residents would then be faced with a very difficult choice: Under what circumstances do they withhold care from one human being to ensure it is available for another? What criteria should they use?

Decisions regarding advanced support hinge on the likelihood of recovery, but these criteria can be tricky to apply to individuals. While no one wants to discriminate based entirely on age, mental capacity, or physician ability – any more than anyone would ever condone making these decisions based on socio-economic status, profession, or skin color – our socialization influences us unconsciously. Hospital systems and states provide guidance on how and when to ration ventilators and ICU beds, but ultimately every choice requires a physician to exercise extraordinary self-awareness, mustering courage and judgement in the face of uncertainty.

In the Kern Institute, we have been crafting a guiding framework for the transformation of medical education, emphasizing the integration of the competencies, capacities, character strengths, and professional identity needed to be a good doctor. This Practical Wisdom – *the ability to do the right thing, at the right time for the right reasons* – is more starkly evident during public health catastrophes like the COVID-19 pandemic, but is always a core aspiration for every good physician.

Luckily, years before COVID-19, Fred and Dr. Lee had discussed his wish to avoid hospitals at the end of life. Once Josephine and the family contacted her, she helped arrange for home hospice. Fred stayed in his apartment and was provided with sedatives and reassurance. Dr. Lee did this even as she was being redeployed to back up her exhausted colleagues at the hospital.

Before long, Dr. Lee was headed, anxiously, to care for the sickest of the sick in settings where she rarely worked, worrying that she might soon be "in over her head." She trusted, though, that her colleagues and the nurses would help. She gathered her courage, humility, and practical wisdom, and headed to the hospital.

* *This story is based on a combination of actual events. The names have all been changed to protect the privacy of the individuals.*

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