

Coombs M, Ayley W, Pickthorne J & Larkin P 2016 'Bringing 'something more' to the bedside: the importance of clinical wisdom at end of life' International Journal of Palliative Nursing 22, (4) 161-162

Author copy. Accepted for publication 15<sup>th</sup> March 2016. DOI 10.12968/ijpn.2016.22.4.161

Title: Bringing 'something more' to the bedside: the importance of clinical wisdom at end of life

Dr Maureen Coombs

Professor in Clinical Nursing

Graduate School of Nursing Midwifery and Health

Victoria University Wellington,

And

Capital and Coast District Health Board

Wellington Regional Hospital

Newtown, Wellington, 6242 New Zealand

Telephone +64 4 463 5363

Email [Maureen.coombs@vuw.ac.nz](mailto:Maureen.coombs@vuw.ac.nz)

Wendie Ayley

Clinical Nurse Specialist

Mary Potter Hospice

48 Mein St

Newtown, Wellington 6242, New Zealand

Jude Pickthorne

Palliative Care Clinical Nurse Specialist

Wellington Regional Hospital

Newtown, Wellington 6242, New Zealand

Dr Philip Larkin

Professor of Clinical Nursing (Palliative Care)

UCD School of Nursing, Midwifery and Health Systems

UCD College of Health Sciences and Our Lady's Hospice and Care Services, Harold's Cross

Belfield Dublin 4, Ireland

Knowing what to do and what to say at end of life can be challenging. There is much that we, and others, bring to this liminal space where people move from life to death; there is much to consider for anyone who works with, and cares for those who are dying.

No matter how experienced we are, nor how long we have been practising, we will never come to a point where we have encountered all of the countless different care situations at end of life where complex needs of patients are to be met. We will never contend with all the range of critical conversations with the dying and those close to them, where concerns and fears are expressed, or withheld. What can be said to the wife of a young man who is distressed, agitated and semi-conscious in the last days of his life? Or to an elderly man who has cared for his wife with advanced heart failure for many years and now has to make a decision about her best place of care at end of life?

To know what to do and what to say in such situations, we use our knowledge of what is current in evidence base and draw on our past experiences to help inform our thinking and actions. However if we reflect on skilled experienced nurses we have worked with, what they bring to clinical situations is more than a simple application of past and present knowledge. They bring clinical wisdom to the bedside of those at end of life. A nurse demonstrating clinical wisdom uses this scientific and experiential knowledge, and then brings more into the clinical situation by considering this knowledge in a more nuanced and contextualised manner.

To be clinically wise, the nurse needs to have all the relevant clinical facts at their fingertips and be emotionally and intellectually sensitive (Haggerty & Grace, 2008). The nurse needs to consider the wider philosophies in the clinical setting and reflect on the ethical, interpersonal, and political influences (Mackie et al., 2012) at play. When being with a nurse who has clinical wisdom we see how the considered and judicious use of this knowledge is informed by a sense of responsibility, analytical thinking, ethical discernment, and a drive for action (Uhrenfeldt & Hall, 2007). Such qualities help navigate the complex minefields within clinical practice. Clinical wisdom is when we

recognise individual patient and family needs, and that what we offer is on the right track, in the context of the practice situation. Clinical wisdom is the insightfulness and instinctiveness that allows us to stand at the bedside and know that what we are about to offer is inappropriate and we need to stop, wait and listen before proceeding.

Clinical wisdom is not a new concept, indeed it relates to the Aristotelian ideal of phronesis, the virtue of practical thought (Davis, 1997). Phronesis encapsulates sound clinical judgement (based on practice experience), critical thinking (based on empirical learning through higher study) and clinical wisdom (application of knowledge and experience to a given situation). Despite this historical connection, the concept of clinical wisdom is well-placed in contemporary end of life practice to facilitate more active decision making with patients and families, change goals of care responsive to need, advise on the alteration or withdrawal of treatment, and emphasise dying as a unique and respected experience for each patient and family.

If we consider a clinically wise approach to the cases set out above, the following may apply. In the case of the young man, clinical judgement would determine that the distress and restlessness witnessed is not likely to resolve spontaneously without a considered medical intervention. Critical thinking would determine the correct use of sedation to settle the patient thereby alleviating symptom burden without hastening demise. Clinical wisdom in this situation is cognisant of the challenges that sedation poses to the man's weakened physiology. Clinical wisdom is aware of the important bond between husband and wife, where the wife's voice can be itself a powerful sedative, calming distress with use of slow and careful sentences to sooth and ease the husband's struggle. A clinically wise nurse appreciates the toll on a wife of sitting beside her dying husband, and seeks solutions to support the wife in her own suffering.

For the elderly man, clinical judgement would involve an assessment of the increasing need for physical care for his wife mindful of available community support, to determine the likelihood of home being the place of care at end of life. Critical thinking will identify the evidence base for

appropriate interventions to facilitate comfort and guide towards a peaceful death. Clinical wisdom looks beyond the immediate need to a couple who have lived together for over 40 years, for whom moving from home is the end of a lifetime of shared understanding, so that changing goals of care include the husband as a partner in the planning of caregiving, rather than only a grieving partner.

We know that clinical judgement and critical thinking can be taught, but how is clinical wisdom imparted? Clinical wisdom is handed down from senior clinical nurse to a new graduate, from expert practitioner to a novice nurse. Over time, with each re-iteration, clinical wisdom evolves becoming more refined and developed. Throughout our careers, we have all learnt from mentors who guided us in the past. This wisdom has ranged from practical, common sense advice that supports everyday care, through to the more abstract, esoteric, or philosophical guidance that perhaps we only fully comprehended with time. This is the 'something more' that clinically wise nurses bring. Some may call this intuition, and the intuitive self is a critical component of good nursing practice. Bringing clinical wisdom to the fore embraces the value of intuition in our clinical practice and makes everyday encounters real and dynamic.

Clinical wisdom needs to be cultivated (Haggerty & Grace, 2008). We learn clinical wisdom from watching others, and to paraphrase Carson (p.46, 2007), that which is learned is 'not so much cognitive as it is personal: how to be a doctor [sic: nurse] to the dying'. This speaks to the process of embedding clinical facts and knowledge into an individualised and situated way of caring. This is not easy. To enable this process to occur effectively needs the support of credible role models, of those who have gone before and worked in the complex world of practice, of credible senior clinical nurses and nurse educators (Adelman-Mullally et al., 2013). The organisations within which we work and the professional organisations that represent us should also recognise the importance of clinical wisdom through promoting excellence in practice, rewarding endeavour, being open to feedback and providing a responsive feedback to critique: all of which sustains a clinical wisdom perspective.

It is important that we have clinically wise nurses who can bring 'something more' at end of life. Clinical wisdom is essential to end of life care (Fins, 2005) and indispensable to the navigation of unforeseen and unexpected circumstances at this time. By bringing clinical wisdom to the bedside of those who are dying, we are recognising the importance of knowledge that has been developed over time. We are acknowledging the expertise of those who have worked with and through end of life in the past, bringing this for the benefit of patients and their families. Clinical wisdom is best perceived as a facet of a tripartite approach which equally values the need for the ability to judge appropriately and uses the resources of higher learning and knowledge to underpin our intervention. Clinical wisdom is then applied to the process and outcome as goals of care change as life's end approaches. The ability to see clinical wisdom within this framework for practice may help to determine the components of what makes the palliative nursing intervention different to those of others who equally, and respectfully, care for dying patients.

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### **Acknowledgements**

We acknowledge the generous support of Genesis Oncology Trust, Mary Potter Hospice, Palliative Care Nurses New Zealand, Capital and Coast District Health Board and Victoria University Wellington who funded the visit of Professor Larkin to New Zealand, thereby enabling this collaborative paper to be conceived and written.