

## Hard to know

*What is hard knowledge?*

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In the wake of any recently completed examination, one needn't wander far to hear residents engaged in (illicit) reflections on the various clinical encounters simulated, more or less accurately, in the examination's multiple stations. A familiar refrain emerges, if one listens at all carefully. There continues to be debate (shall we say)—among residents and across programs—as to the relative merit of soft (ie, “touchy-feely”) knowledge and skills, as opposed to so-called hard knowledge (“Just the facts, ma’am”).

Residents at this stage of their careers are keen to learn and even more keen to get on with healing the world. And this is good. They have a thirst for therapeutic potency—a drive to do things, to fix problems. These emerging new clinicians are quite definite about what they know and what they need to know. Often sceptical that experienced staff physicians have much to offer, they expect faculty members to know their facts cold and to be up to date on the latest practice guidelines.

But I suggest that there exists a certain paradoxical confusion here. That is, given that many of today's medical “facts” will be found to be tomorrow's errors and misapprehensions, this so-called hard knowledge ought perhaps to be considered, if not soft, certainly malleable and subject to erosion.

And what about so-called soft knowledge, the touchy-feely stuff? While evidence-based “facts,” guidelines, and therapeutics are patently impermanent, and therefore arguably “soft,” surely what does not change is human nature.

Knowledge of “human being-ness,” of the narrative, economic, and spiritual elements of our patients' diseases; this is “hard” knowledge—hard to memorize, hard to teach, and impossible to master. Nevertheless, without this knowledge, how can we really help our patients—and, perhaps more importantly, how can we not harm them?

And so let us propose that, if neophyte physicians are to use their hard-earned “soft” knowledge of facts and figures, anatomy and physiology, and guidelines and treatments to the greatest benefit, they will do well to incorporate the following “hard” knowledge suggestions.

- Know yourself. As a physician each of us is very much like a potent drug—with indications, contraindications, and potential anaphylaxis—for our patients.
- Be wary of the blending of power and trust. This can be a recipe for abuse of power and the development of an “MDeity syndrome.”
- Understanding the patient is the bottom line. Patients universally need to be respected, listened to, understood, and believed; only then can they be cared for. Without understanding, we are nothing. If you understand your patient, you are freed to have the courage to say the unspeakable “I don't know” and “I am sorry.”

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Together we bear the burdens and enjoy the rewards of working together as teachers and learners. The formation of young clinicians into effective agents of healing needs to confront the traditional concept of hard knowledge. Our task is more formational than informational. Our joint concerns are about medicine as a moral enterprise, about making right choices that promote the good of those we serve. Let us make

sure that residents leave our programs with inquisitiveness, imagination, and compassion that will sustain them through a lifetime of caring, during which, with practice, they might ultimately gain a “hard” knowledge or an enduring wisdom that they can pass on to their students. ❁

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