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CULTIVATING CAPACITY:

Phronesis, Learning, and Diversity in Professional Education

Your assumptions are your windows on the world. Scrub them off every once in a while, or the light won't come in.

Alan Alda

INTRODUCTION

In this chapter I consider phronesis in terms of what it has to offer our thinking about learning and diversity in professional education. I approach the topic as an educator who has participated in professional education contexts in both medicine and education. I begin with a brief narrative to situate my thinking and illustrate one way in which I work to disrupt assumptions about professional education in the educational context. As the chapter progresses, I consider what it might take to cultivate the 'habits of mind' needed to build capacity for phronetic action in the professions.

PROFESSIONAL EDUCATION

I began teaching in 1982. At that time in Ontario, Canada, regional professional education was largely the domain of teacher federations. Teachers were routinely surveyed about their professional needs so that professional development days could be planned in response to those needs. Typically, sessions began with a motivational keynote address that led to much discussion over the days and weeks to follow. Numerous breakout sessions were offered, and teachers chose those sessions that addressed the subject area or pedagogical needs for which they were seeking support. The sessions were frequently participatory, and we looked forward to spending these days working with colleagues from other schools, talking about ideas we had, and sharing the strategies we were using in the classroom. Further opportunities were available for dialogic interaction around our subject area by participating in one of the teams writing curriculum. I looked forward to working on these projects because of the meaningful opportunities for learning and the engaging discussions about our practice.

By the mid-1990s, much had changed. A standardised curriculum had been introduced, followed quickly by standardised assessment and evaluation procedures and a standardised electronic reporting process. The number of days allocated for

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professional education via school districts was reduced, and the increase in mandated changes shifted both the control and focus of the experiences from professional development that emerged from regional needs, to 'training' in the new provincial standards.

By then, I was working as one of the central program staff at the Board of Education. Responsibility for generating the new curriculum guidelines and procedures was assumed by the Ministry of Education and Training in a much more significant way. The support staff role (previously considered 'a position of additional responsibility') transformed into a position that required us to disseminate materials and reproduce our received training in a 'train-the-trainer' format. Information was scripted and *delivered* in a top-down system, which, for me, was the antithesis of teaching. All teachers, regardless of years of experience, level of education, or competence in the classroom were subjected to identical sessions. I recall feeling that this process of 'training' represented the direct opposite of everything I knew about good teaching, and it led to a sense of de-professionalisation and demoralisation. How could we expect teachers to create engaging and stimulating learning environments for students when they weren't themselves being engaged as professionals and intellectuals? How could we ask them to differentiate their instruction on the basis of student needs when we completely ignored their differences and needs? The 'train-the-trainer' experience has haunted me ever since, and I continue to return to it in my research time and time again.

EDUCATING PROFESSIONALS: AN EXAMPLE FROM A FACULTY OF EDUCATION

Educating professionals brings with it a set of assumptions about its learners. At the faculty of education where I serve as a teacher–educator, students and faculty bring assumptions into their learning environment. Gaining access to the program is highly competitive. Recognising this admission's context, I typically gather information from my students early in a course. For example, in an English Language Arts class, I ask the following questions:

- Tell me about your literacy background. What led you here? What are your long-term goals?
- List a sample of the texts that you enjoyed this summer.
- What would you like me to know about you as a learner?

This information allows me to plan my teaching in a way that accesses the student-as-informant (Harste, Woodward, & Burke, 1984), and the results are always instructive. Eventually, I began to consider other ways to use the information that students provided to educate the classroom community. Gathering such information and making it visible became a first step toward accessing the knowledge of practitioners in ways that could help them to problematise their current understandings and begin to negotiate the gaps in their knowledge. For example, I developed 'mini challenges' to help teacher candidates prepare for their work with students in classroom settings, such as the Case of Hsilgne, below:

Mini Challenge #1 The Case of Hsilgne

During the first observation day, your Associate Teacher introduces you to Hsilgne. She is new to the school and the Associate Teacher has asked you to get to know her, consider what her needs are and what approach you might take to help Hsilgne transition to her new class and into the curriculum.
In your conversations with Hsilgne, you learn the following:

- She can learn via lecture style if it incorporates movies, stories, parodies, etc., as she recognizes that she has a short attention span.
- She needs to take her time to complete her work.
- Sometimes she misses instructions when too much information is presented all at once.
- She finds it helpful to discuss her ideas with others before having to write, as she needs to be able to practise or think things through before applying what she is learning.
- She finds speaking publicly to be anxiety-provoking.
- She is a hard worker and loves to learn new things, but often needs to read material more than once before she comprehends it.
- Once she is comfortable with a topic, she is willing to take a leadership role.

The Associate Teacher sits down with you, asks you what information you have gathered, what the information tells you about the student, and what you need to do as her teacher, to help her experience success in your classroom.

I share this case with my class and encourage them to discuss their responses in small groups. When we come back together as a whole class, the suggestions in response to this activity typically include the following:

- This student sounds like she is immature, and maybe has a learning disability.
- Hsilgne is highly anxious and has a lot of learning problems and it appears that there are some socio-emotional ones as well. She will need a lot of support.
- She seems to have a good grasp on what it is that she needs in order to learn, so perhaps someone has been helping her develop learning strategies along the way.
- She sounds like a typical teenager, struggling with competing identities.

After some discussion about the possible problems that Hsilgne may or may not be challenged by, I pause and look at the class for a moment without speaking. Then, I tell them that I want them to listen very carefully to what I am about to say and remember these words as they enter the teaching profession: *Hsilgne,* I tell them, is YOU. It is the word *English* spelled backward, and *she* is a composite of the things that you have told me that you want me to know about *you* as learners.

Without fail, this brief activity serves as a startling disruption to some of the assumptions that teacher candidates bring to their professional education environment—namely, that those who have already completed an undergraduate degree with sufficient success to gain acceptance into a very competitive

professional education program must all be independent learners requiring little in the way of direct instruction or differentiated learning strategies. The activity serves "to spatialise the conventional narrative, and to relocate the autobiographical in its social and cultural landscape" (Kamler, 2001, p. 2) in ways that open their thinking to alternative perspectives and experiences.

EDUCATING MEDICAL PROFESSIONALS

The need to acknowledge and clarify the assumptions we bring to our professional practice becomes even more pronounced when we move into what have long been considered the *elite professions,* such as medicine. What does it mean to move knowledge about teaching into a global medical education community in ways that demonstrate complex understandings of diversity? Over the past few years, my work in a professional education capacity with physicians has revealed that, like our work with teacher candidates, we must first convince medical educators that diversity in learning exists at all levels. The faculty in many academic medical institutions have increasingly witnessed a growing diversity in the classroom (e.g., in terms of gender, class, age, culture, and language). The greater challenge is to better understand what is not as visible, that is, the complex ways in which people learn.

As an educator working with residents and physicians in a highly competitive field, I have observed that assumptions about who residents are as learners often becomes conflated with their intellectual ability. Both physician-educators and the residents themselves are often surprised that despite having qualified to enter a highly competitive program, some struggle with the learning. The typical response by most faculty (and often the students themselves) to their struggle is to 'pathologise the learner'; in other words, to focus responsibility for the struggle on those activities that the learner may or may not be doing.

Residents have sought help repeatedly (from across the country and usually with a promise of anonymity) under a cloud of fear and shame, seeking support, first, to understand why they are struggling and, second, to negotiate ways to address their needs. For many, the new learning context they encounter in their residency is their first experience of struggling academically. As a result, we focus much of our work on helping medical faculty to question their assumptions about learners and to ensure that, as educators, we share a collective responsibility to find ways to address the learning needs of our students. The impetus to increase diversity in medical programs and to build and maintain competent and sustainable human resources in our own communities and in outreach settings must, for *ethical* reasons, include a parallel commitment to develop professionals and programs that are adequately prepared and supported to meet the learning needs encountered in this increasingly diverse context. Disrupting assumptions borne from a more monolithic educational past becomes even more critical as the participants, the contexts, and the knowledge needed are increasingly responsive to an ever-changing context of global needs and the diversity entailed by such demand.

A ROLE FOR THE INTELLECTUAL VIRTUES

In the Nicomachean Ethics, Aristotle examined the conditions wherein moral responsibility might be ascribed to individuals. I wonder, might Aristotle's notion of phronesis offer a "unifying and essential habit of the mind" (Birmingham, 2004, p. 314) to guide the work of medical educators in today's global context? Eikeland (2006) suggests that a return to Aristotle

> springs from a deeply felt desire for finding concepts to grasp kinds of knowledge and skills that are directed towards understanding and acting in accordance with requirements of the concrete situations we find ourselves in. The search is for non-technical, non-mechanical ways of recognizing the sovereignty and independence of our everyday cognitions and judgments, without constantly being referred and subordinated to "science." Phronesis appears to be a concept with great potential for this. (p. 6)

Phronesis, as Aristotle defined it, is a "state of grasping the truth, involving reason, concerned with action about what is good or bad for a human being" (Aristotle, trans. 1999, p. 154). In professional practice, and medical education is no exception, the dominant discourse has long been steeped in the language of technical and scientific approaches (Schön, 1983). Physicians in particular, are trained to aim for maximal certainty and "are rewarded for efficiency, technical skill, and measurable results" (Phillips, 1994, p. 1). Instrumental rationalism, however, can only take us so far. Anne Phelan (2005) has fittingly noted that educators "must learn to recognize that generalizable knowledge is fragile in the face of practice" (p. 353). Because medical residents have been inculcated into a reverence for generalisable knowledge during their undergraduate medical training, difficulties emerge in practice when they need to apply clinical judgement or "the exercise of practical reasoning in the care of patients" (Montgomery, 2006, p. 37). Montgomery further argues that the "obstacle they encounter is the radical uncertainty of clinical practice: not just the incompleteness of medical knowledge but, more important, the imprecision of the application of even the most solid-seeming fact to a particular patient" (p. 37).

At this point, it may be instructive to consider what is meant by *practice*. MacIntyre (1984) describes it as:

> any coherent and complex form of socially established cooperative activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended. (p. 187)

Practice, and professional practice in particular, is therefore both an intellectual and a moral enterprise. In their clinical education, physicians are trained to expect the unexpected; to make decisions in the absence of information and in the presence of conflicting information. How might we encourage those who mentor, supervise, and

teach residents to apply such contextualised understanding to the pedagogical practices in their resident education programs? In other words, how might we shift the architecture of medical education 'training' at the residency level, in particular, to a design that positions learners as professionals participating in improving their education, and therefore their ability to make informed decisions?

Donald Schön (1973) suggests that "a social system learns when it acquires new capacity for behaviour . . . and must also learn to create the systems for doing so" (p. 109). He later considers practitioners' "capacity for reflection on their intuitive knowledge in the midst of action and use this capacity to cope with the unique, uncertain, and conflicted situations of practice" (Schön, 1983, vii–viii). Reflexive analysis of practice (what Schön calls 'reflection on action') offers a means for practitioners to deliberate about the ends and goods involved—a deliberation sorely lacking in a purely technical approach. Indeed, Pring (1996) has argued that practitioners "no longer deliberate about the aims of education as part of their professional responsibility; instead they deliberate about the means to achieve externally imposed ends as part of their craft" (p.110).

Reflective practice as a means to knowledge construction is often criticised for its subjectivity in having educators come to understand their practice initially through personal interpretive lenses. The longer one teaches, the greater the likelihood the theoretical underpinnings to practice will become tacit and the practices routine. While routines can be beneficial by helping us to manage the complexities of our day without attending to every detail, routinised practices are more likely to then remain unexamined (Tripp, 1993). Yet, it is precisely the process of examining those routine practices that opens the door to the work of reflective practice. Further scrutinising those actions is highly likely to influence the future actions and decisions made by professionals in ways that may directly affect the experiences of patients or students, an activity that Tait (2008) argues is the "impetus for reflective practice" (p. 153).

Once educators are able to acknowledge and articulate the theories and assumptions that underpin their practice, they are in a better position to critique their practice and to subsequently act upon the insights gained. Birmingham (2004) suggests that "reflection is centered on the personal character of the individual, but is expressed in actions such as critically examining instructional goals, caring for students, and ensuring just treatment for students" (p. 316). She insists that the model of reflection needed is one "in which knowing and thinking are inextricably bound up in action, emphasising [Schön's] terms *reflection-in-action* and *reflection-on-action*" (p. 316). The capacity to understand precisely *which* action is best suited to a particular situation draws on the notion of phronetic action.

PHRONETIC ACTION IN CONTEXT: THE 21ST CENTURY LEARNER

More than ever before, learners who come before us no longer rely solely on an individual instructor or a particular text to gather their information. Access to information, even in developing countries, is growing and is radically changing the way learners think about situations and the prior knowledge, skills, and experiences

they bring to a teaching and learning context. Conversely, the expectations that many faculty continue to bring to the teaching and learning environment too often reflect a passive learner from a different generation—a learner who took notes, followed directions, and progressed in predictable and controllable ways. In today's global society, our classrooms are increasingly multicultural, and our students, especially the younger generation, engage in their learning and interaction in ways not experienced by an older generation.

Returning to Aristotle (as cited in Flyvbjerg, 2001), we are reminded that phronesis is that intellectual activity that "focuses on what is variable, on that which cannot be encapsulated by universal rules, on specific cases; it requires consideration, judgment and choice" (p. 57). A first step in moving away from the more traditional, orthodox teaching approach involves shifting the culture of institutional and professional educators' expectations in ways that acknowledge the fluidity and complexities of the global learning environment and its students. The shift in cultural awareness requires a concurrent willingness to assume professional responsibility for one's actions. Dewey (1932, 1933) refers to this willingness as a whole-heartedness and open-mindedness that I argue better positions educators to *act phronetically*, that is, in ways that enhance the quality of the teaching and learning experience for the entire community.

To *act phronetically* requires a shift in thinking about both our learners and our pedagogical responsibilities for their professional education. Expect learners to arrive with diverse skills, knowledge, and abilities that go beyond the prerequisite training from their undergraduate medical preparation. Plan their educational experiences in ways that acknowledge these differences, and model the precise kind of phronetic action you expect them to apply in their clinical practice. As educators, we are teaching in every interaction, every decision, and every response—including every silence. To act phronetically is to behave in a way that demonstrates ethical practicality; doing what is needed, when it is needed, to bring about the desired ends through our actions. Acting phronetically is both intellectual and moral work. Indeed, Dunne (1993) claims that "phronetic action can't exist without both intellectual and moral conditions of the mind" (p. 264), conditions that may "counter the overreliance on techne seen in skills-based movement[s]" (p. 268).

Briefly, Narvaez (2005, 2006) finds a moral expert to be someone who demonstrates high levels of: (1) ethical sensitivity (e.g., connecting with others, awareness of people's feelings, controlling one's social biases, understanding moral and social situations); (2) ethical judgement skills (e.g., applying a code of ethics, reasoning about what needs to be done, determining the best course of action); (3) ethical focus (e.g., making morality a priority, aligning one's moral values with one's identity, being an active community member, deriving meaning from living a moral life); and (4) competence in ethical action (e.g., implementing morally related knowledge and action, engaging in moral leadership, showing courage and resiliency in the face of hardship).

In many ways, the characteristics of a moral expert run parallel to the aims of clinical education that seeks to "transform students into reliable practical reasoners … as they work out what is best to do for a particular patient" (Montgomery, 2006,

p. 5). Furthermore, Montgomery claims that "it is the conjunction of the two: the rational, clinical experience, and scientifically informed care of sick people" but notes that "its essential virtue is clinical judgment, the practical reasoning or phronesis that enables physicians to fit their knowledge and experiences to the circumstances of each patient" (p. 33). How might we adapt that same capacity for phronesis that is needed to care appropriately for individual patients and apply it to pedagogical decision-making for students and residents?

To begin, we need to disrupt the assumptions that medical educators bring to this role. As illustrated with the Case of Hsilgne, we need to break down the misconceptions that exist about teaching and learning in the professions. Since most medical educators have little or no professional educational preparation (e.g., teaching and learning theories and strategies, curriculum development, and assessment and evaluation), they are more likely to re-inscribe forms of pedagogy that they themselves have experienced (including deficit forms). Typically, in our research, this re-inscription translates into traditional, teacher-centred approaches that view learners as a homogeneous group. Helping medical educators to understand diverse learning needs and the varying approaches to meet those needs is a significant challenge.

Aristotle held that experience was essential to developing phronesis. Within the current structure of many medical education institutions, gaining the kind of educational experience that may lead to phronetic action is difficult. Traditional undergraduate medical education scenarios involve large classes often taught by a long roster of highly trained physicians or specialists who present to the class as infrequently as once per year. The lack of teacher–learner interaction inhibits the formation of relationships necessary to inform teacher practice and decision-making. For example, ratings on teacher effectiveness and data measuring students' learning are typically shared with faculty, but not until long after their class is over and in a numeric format that has been described by some as "utterly meaningless."

In a residency program for physician specialists, the opportunities for individual and small group instruction prevail. However, effective pedagogical feedback continues to be limited or non-existent (Amman, Van Deven, & Hibbert, 2010). Since phronesis evolves from experience, the need for pedagogical feedback is critical. "Once we descend to particular cases," Dunne (1993) explains, "we are no longer securely in the governance of techne, which is always limited to general rules" (p. 259). The need to take action must include an ability to combine those general rules that guide our practice with a more sophisticated ability to discern the unique characteristics of the particular case or context.

Kathryn Montgomery (2006) has introduced a framework for building capacity for phronetic action in medical education as it relates to patient care. In her book, *How Doctors Think* (Montgomery, 2006), she makes the case that medicine is not a science, but a practice that draws on science, and that the "physician's best clinical instrument—diagnostic or therapeutic—is the physician herself" (p. 162). The same is also true for teaching. Just as residents must "recast the biology they have spent years learning into clinically relevant cases" (p. 51), medical educators must recast what they know (have learned) clinically into diverse and pedagogically

relevant teaching practices in order to successfully mentor and instruct the next generation of physician-educators.

CAN DOCTORS THINK?

Creating pedagogically engaging experiences for students requires a willingness to think deeply about the complexities of *practice*—both clinical and educational. In a 2008 issue of *The Lancet*, Anthar Yawar asks the question, "Can doctors think?" He eventually concludes that doctors might benefit from "training in ideas…[to] develop the flexibility and depth ordinarily attributed to insightful philosophers" (p. 1286). However, if we intend to develop the type of professional, reflective thinking that will support phronetic action, more than training is required. We need to cultivate an institutional culture and conditions wherein thinking, reflection, and ideas thrive and are modelled by all members in the profession. Montgomery (2006) reminds us that if "medicine were only a science, physicians could establish their clinical competence by answering test questions correctly" (p. 138). In many institutions, answering test questions correctly is the dominant accountability system used to 'measure' competency. The test-competency-as-gatekeeper tradition permeates the concerns of residents, whose overriding focus is successfully passing their board exams. "Medicine" after all, "is not, by and large, a reflective profession" (Klaus, 2007, p. xiv).

Disrupting well-established assumptions and cultivating a different culture takes time, energy, and the support of key champions within the institution who are dedicated to educational reform. Cultivating a culture that promotes both reflection and the ethical responsibility required to improve the conditions for learning for all students should be an easy alliance for professionals educated in an ethic of care. However, the rigid hierarchical system in medicine that Montgomery observes for medical students and residents can be made even more palpable when non-physician educators are introduced. Integrating new ways of thinking can be likened to introducing new dance steps into a well-rehearsed routine. If we can help doctors remember that in their profession, they are eternally both a student *and* a teacher and also help them to reconnect with what it means to be a learner, our work has begun.

In *Treatment Kind and Fair: Letters to a Young Doctor*, Perri Klaus (2007) offers sage advice to her son as he follows her example and enters the medical profession: "When all else fails, look at the patient" (p. 62). The same advice can be offered to medical educators. Basic skills do not define a profession. Choosing a profession includes accepting all the intellectual and moral responsibilities that accompany that profession as we will need to decide what to do, in each situation for the good of humankind. In medicine, these responsibilities do not end with patient care. These responsibilities extend to the profession as a whole, and to ensuring that those who follow us are better prepared than we were, to engage in an increasingly diverse world. We cannot fully grasp our responsibilities without first scrubbing off our 'windows on the world.'

NOTE

The epigraph to this chapter is drawn from "The Wilderness of Your Intuition," a commencement address by Alan Alda at Connecticut College, New London, Connecticut, May 20, 1980, available at http://aspen.conncoll.edu/programs/pfr.cfm.

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