Megan E. L. Brown
Mario Veen
Gabrielle Maria Finn *Editors*

Applied Philosophy for Health Professions Education

A Journey Towards Mutual Understanding

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Editors
Megan E. L. Brown
Imperial College London
London, UK

Hull York Medical School
York, UK

The University of Buckingham
Buckingham, UK

Gabrielle Maria Finn
The University of Manchester
Manchester, UK

Hull York Medical School
York, UK

Mario Veen
Erasmus University Medical Center
Rotterdam, The Netherlands

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This book is dedicated to the memory of Flint Victor Brophy.

Foreword

We want your technology, but not your philosophy.

A Dean spoke these words to me with a determent facial expression. He wanted the problem-based learning technology (e.g., small group discussions, self-directed learning) for his students, without exposing the students to philosophies underlying the education (e.g., humanism, constructivism). These philosophies would not match with the students' cultural values. This made me reflect on how philosophy relates to education, and how education relates to philosophy. We investigated these two questions in different national cultures and found that: problem-based learning philosophies affect student's ideas, and the student's ideas affect problem-based learning. Education and philosophy are inextricably linked. The Dean dreamed a hopeless dream with his wish for education without philosophy.

I'm a journal editor, an educational researcher, and an educator, and I find philosophy to be important, but distant and inaccessible (or a closed cave to stay within the philosopher's world). Writing on philosophical topics seemed more something for my smart colleagues form the medical ethics department, than for a normal academic like myself. They have studied philosophers' complex ideas written down on many pages in even more complex language for many years. I had not come further than Freire's Pedagogy of the oppressed—which I loved—and an attempt to read Arendt's The human condition—which I never finished. But now there is the *Applied Philosophy for Health Professions Education: A Journey Towards Mutual Understanding* to open the world of philosophy for educators. The book offers both an introduction and a more in-depth discussion of the philosophy of health professions education.

Applied Philosophy for Health Professions Education introduces educators into a wide range of philosophical topics. Several chapters provide a philosophical perspective on contemporary educational issues, e.g., assessment, identity formation, empathy, social media. Other chapters focus on what philosophical concepts can mean for health professions education, e.g., Stoicism, ontology, phronesis, feminism. Two chapters are devoted to the philosophy of science. These two chapters are relevant for both producers (i.e., researchers) and consumers (i.e., educators, policy

makers) of health profession education research. I was personally excited that the editors have included a chapter on Freire's work. The editors—Megan Brown, Mario Veen, and Gabrielle Finn—have taken the book's subtitle *A journey towards mutual understanding* seriously. Most chapters have been authored by a combination of clinicians and/or educators, and experts in philosophy. These unique author combinations result in a book that combines in-depth exploration of philosophical concepts, with practical examples and cases, written in a clear and accessible language. The editors and authors have made a remarkable performance by offering us an accessible, practical, and scholarly introduction into the meaning of philosophy for the health professions education. This is the first book to accomplish bridging the gap between both worlds.

Dear health professions education reader, you no longer have to be afraid of philosophy. And this book may give you the language (and the will) to engage that Dean who demands your educational technology but dismisses the philosophy underpinning them.

Professor Erik Driessen
Professor and Chair, Department of
Educational Development and
Research, Faculty of Health, Medicine
and Life Sciences
Maastricht University
Maastricht, The Netherlands

Preface

This book is a journey towards mutual understanding—it says so in the title—but between whom? In this book we bring together the voices of emerging and established healthcare professionals, educators, and researchers with the voices of philosophers. In doing so, we hope we have captured the beginnings of an applied philosophy for health professions education that is both grounded in theory, but practical in orientation. We, the editors, are all interested in or have studied philosophy, yet have noticed during our time in health professions education that it is relatively underutilised within the field. We hope in reading this book that you will begin to see what insights philosophy can offer our interdisciplinary field and, in doing so (and perhaps putting some of these insights into practice in your own educational or research practice), that we can move the field towards a more truly interdisciplinary position.

This book was written for all of those interested or invested in health professions education—from 'on the ground' clinicians and educators, to those with interests in research and formal academic positions. Some chapters are more introductory in nature, whilst others offer a more theoretical 'deep dive' into various philosophies. This is intentional, and we hope there is something for everyone in this book. We envision this book could be particularly useful for those completing postgraduate studies in health professions education and research.

We are indebted to the contributing authors of this edited volume for their wisdom, effort, and insight. In alphabetical order by surname, the following trainees, undergraduate students, postgraduate students, clinicians, educators, researchers, philosophers, and those that defy easy labelling contributed to this book:

- Rola Ajjawi. Centre for Research in Assessment and Digital Learning, Deakin University, Melbourne, VIC, Australia. Email: rola.ajjawi@deakin.edu.au
- Joop Berding. Before his retirement affiliated with Rotterdam University of Applied Sciences, The Netherlands. Email: jwa.berding@ziggo.nl
- Robyn Bluhm. Department of Philosophy and Lyman Briggs College, Michigan State University, East Lansing, Michigan, USA. Email: rbluhm@msu.edu

- Megan E.L. Brown. Medical Education Innovation and Research Centre, Imperial College London, UK and Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: megan.brown@imperial.ac.uk
- Jamie Buckland. Department of Philosophy, University of York, UK. Email: jamie.buckland@york.ac.uk
- Jessica L. Bunin. Department of Medicine, Uniformed Services University of the Health Sciences. Email: jessica.bunin@usuhs.edu
- Benjamin Chin-Yee. Division of Hematology, Western University, London, Canada, and Rotman Institute for Philosophy, Western University, London, Canada. Email: benjamin.chin-yee@lhsc.on.ca
- Camillo Quinto Harro Coccia. University of Cape Town, Cape Town, South Africa. Email: camillo.coccia@uct.ac.za
- Paul Crampton. Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: paul.crampton@hyms.ac.uk
- Adam Danquah. Faculty of Biology, Medicine and Health, University of Manchester, Manchester, UK. Email: adam.danquah@manchester.ac.uk
- Anne de la Croix. Amsterdam UMC, Research in Education, Faculty of Medicine, Vrije Universiteit Amsterdam, The Netherlands. Email: A.delacroix@amsterdamumc.nl
- Tim Dornan, Queen's University Belfast, Northern Ireland, UK and Maastricht University, The Netherlands.
- Angelique N. Dueñas. Department of Medical Education, Northwestern University Feinberg School of Medicine, Chicago, IL, USA and Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: angelique.duenas@northwestern.edu
- Sarah Louise Edwards. University Hospitals of Leicester, Leicester Royal Infirmary, Leicester, UK. Email: se181@leicester.ac.uk
- Kevin Eva. Centre for Health Education Scholarship, University of British Columbia, Vancouver, Canada. Email: kevin.eva@ubc.ca
- Gabrielle M. Finn. Division of Medical Education, School of Medical Sciences, Faculty of Biology, Medicine and Health, The University of Manchester, Manchester, UK and Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: gabrielle.finn@manchester.ac.uk
- Jonathan Guckian. Leeds Teaching Hospitals Trust, Leeds. Email: Jonathan.guckian@outlook.com
- Neil Guha. School of Medicine, University of Nottingham, Nottingham, UK. Email: neil.guha@nottingham.ac.uk
- Frederic W. Hafferty. Division of General Internal Medicine and Program in Professionalism and Values, Mayo Clinic, Rochester, Minnesota, USA. Email: Hafferty.Frederic@mayo.edu
- Nigel Hart. School of Medicine, Dentistry, and Biomedical Sciences, Queen's University Belfast, Northern Ireland, UK. Email: n.hart@qub.ac.uk
- Jenny Johnston. School of Medicine, Dentistry, and Biomedical Sciences, Queen's University Belfast, Northern Ireland, UK. Email: j.l.johnston@qub.ac.uk

- Amelia Kehoe. Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: millie.kehoe@hyms.ac.uk
- Martina Ann Kelly, Undergraduate Family Medicine, Cumming School of Medicine, University of Calgary, Calgary, Canada. Email: makelly@ucalgary.ca
- Abigail Konopasky. Center for Health Professions Education, Uniformed Services University of the Health Sciences and Henry M. Jackson Foundation for the Advancement of Military Medicine. Email:abigail.konopasky.ctr@usuhs.edu
- William Laughey. Health Professions Education Unit, Hull York Medical School, University of York, UK. Email: william.laughey@hyms.ac.uk
- Tim LeBon. Psychotherapist, UK. Email: timlebon@gmail.com
- Alexander MacLellan. Department of Psychology, University of Bath, Bath, UK. Email: akem20@bath.ac.uk
- Annalisa Manca. School of Medicine, Dentistry, and Biomedical Sciences, Queen's University Belfast, Northern Ireland, UK. Email: annalisa.manc@gmail.com
- Nabilah Yunus Mayat. Airedale NHS Foundation Trust, UK. Email: n.mayat@nhs.net
- Barett Michalec, Edson College of Nursing and Health Innovation, CAIPER, Arizona State University. Email: barret.michalec@asu.edu
- Jacob Pearce. Specialist and Professional Assessment, Australian Council for Educational Research, Camberwell, Victoria, Australia.
- Grace Peters. Veterinary Communication for Professional Excellence, Colorado State University, United States. Grace.peters@colostate.edu
- Nicole Piemonte, Creighton University, School of Medicine, Phoenix Regional Campus
- Bryan C. Pilkington, School of Health and Medical Sciences, College of Nursing, and Department of Philosophy, Seton Hall University and Hackensack Meridian School of Medicine
- Margaret Plews-Ogan, University of Virginia School of Medicine, USA. Email: mp5k@hscmail.mcc.virginia.edu
- Marina Politis. School of Medicine, Dentistry and Nursing, University of Glasgow, Glasgow, UK. Email: 2364733p@student.gla.ac.uk
- Wouter Pols. Before his retirement affiliated with Rotterdam University of Applied Sciences, The Netherlands. Email: wouterpols1@gmail.com
- Holly Quinton. Queens Road Surgery, Consett, County Durham, UK.
- Cristina Richie. Philosophy and Ethics of Technology, Technische Universiteit Delft, Delft 2628, The Netherlands. Email: c.s.richie@tudelft.nl
- Charlotte Rothwell. NIHR Applied Research Collaboration North East and Cumbria, Newcastle University, UK. Email: charlotte.rothwell@ncl.ac.uk
- Tinu Ruparell, Department of Classics and Religion, University of Calgary, Canada.
- Sven Peter Charlotte Schaepkens. Erasmus Medical Centre, Rotterdam, The Netherlands. Email: s.schaepkens@erasmusmc.nl

- Kenneth E. Sharpe. Swarthmore College, Swarthmore, Pennsylvania, USA. Email: Kenneth.e.sharpe@gmail.com
- Walter Tavares. The Wilson Centre for Health Professions Education, University Health Network, University of Toronto, Temerty Faculty of Medicine, Toronto, Ontario, Canada. Email: walter.tavares@utoronto.ca
- Jon Tilburt, Mayo Clinic, Scottsdale, Arizona.
- Marije van Braak. Erasmus Medical Centre, Rotterdam, The Netherlands. Email: m.vanbraak@erasmusmc.nl
- Lara Varpio. Center for Health Professions Education Uniformed Services University of the Health Sciences Center for Health Professions Education. Email: lara.varpio@usuhs.edu
- Mario Veen. Department of General Practice, Erasmus Medical Center Rotterdam, The Netherlands. Email: m.veen.1@erasmusmc.nl
- Simon Verwer. Amsterdam UMC. Email: s.verwer@amsterdamumc.nl
- Lena Wånggren. School of Literatures, Languages and Cultures, University of Edinburgh, UK. Email: lena.wanggren@ed.ac.uk
- Tasha R. Wyatt. Center for Health Professions Education, Uniformed Services University of the Health Sciences, Bethesda, Maryland; USA. Email: Tasha.wyatt@usuhs.edu

USA

Megan E. L. Brown
Mario Veen
Gabrielle Maria Finn

Contents

Abbreviations

AAMC	Association of American Medical Colleges
ACP	American College of Physicians
AI	Artificial Intelligence
ASHA	American Speech-Language-Hearing Association
BCE	Before Common Era
BJGP	British Journal of General Practice
CBME	Competency Based Medical Education
CBT	Cognitive Behavioural Therapy
CHA	Cambridge Health Alliance
CIC	Harvard Medical School Cambridge Integrated Clerkship
CoP	Community of Practice
COVID-19	Coronavirus disease 2019
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CRT	Critical Race Theory
EDI	Equality, Diversity and Inclusion
ER	Emergency Room
GED	General Educational Development tests
GMC	General Medical Council
GP	General Practice
HCP	Healthcare professionals
HMS	Harvard Medical School
HPE	Health Professions Education
IBM	International Business Machines Corporation
ICE	Ideas, Concerns and Expectations
IFMSA	International Federation of Medical Students' Associations
IPE	Interprofessional Education
JAMA	Journal of the American Medical Association
JSE	Jefferson Scale of Empathy
LGBTQIA+	Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexuality, Plus (Includes many other terms such as non-binary and pansexual)

LIC	Longitudinal Integrated Clerkship
LSS	Liverpool Stoicism Scale
MA	Master of Arts
MD	Doctor of Medicine
NHS	National Health Service, United Kingdom
NYU	New York University
OSCE	Objective Structured Clinical Examination
PIF	Professional Identity Formation
SABS	Stoic Attitudes and Behaviours Scale
SEAM	Harvard Students for Environmental Awareness in Medicine
SoMe	Social Media
SP	Simulated Patient
UK	United Kingdom
US	United States
UVA	University of Virginia School of Medicine
WA	Widening Access
WHO	World Health Organisation
WP	Widening Participation

Chapter 1
Philosophy as Praxis

Megan E. L. Brown, Mario Veen, and Gabrielle Maria Finn

The best physician is also a philosopher

Galen, Title of a Treatise (165–175 BCE), cited in Chapter 18 of this volume

Although health professions education has philosophical roots (Veen and Cianciolo 2020), it has drifted far from its original moorings as the field has developed and is little-represented within contemporary health professions discourse. Philosophy asks fundamental questions about human experience, knowledge, ethics, and truth. Taken from the Greek words 'philein' which means 'to love', and 'sophia' which means 'wisdom', philosophy offers a new lens through which contemporary issues within medical education can be scrutinised (Veen and Cianciolo 2020).

The question of just what philosophy 'is' is a contentious one (Wilson 1986). The Oxford Companion to Philosophy notes this debate but does offer a short definition—"philosophy is thinking about thinking" (Honderich 1995). Another definition, offered by Deleuze and Guattari (1991), is that the task of philosophy is to create, form and invent *concepts*. Take, for instance, the term 'health professions education', about which we could ask: 'what is health?'; 'what is professionalism?'; 'what is education?'. The chapters in this book engage with deep questions about these fundamental concepts in our professions.

M. E. L. Brown (✉)
Imperial College London, London, UK
e-mail: megan.brown@imperial.ac.uk

M. E. L. Brown · G. M. Finn
Hull York Medical School, University of York, York, UK
e-mail: gabrielle.finn@manchester.ac.uk

M. Veen
Department of General Practice, Erasmus University Medical Center, Rotterdam, The Netherlands
e-mail: m.veen.1@erasmusmc.nl

G. M. Finn
The University of Manchester, Manchester, UK

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But how do we go about answering such fundamental questions? In *The Purpose of Philosophy* (199978), Isaiah Berlin argues against the idea that philosophy is about unanswerable questions. He distinguishes philosophical questions from questions that may be hard to answer, or even, in principle, unanswerable, such as scientific questions or formal mathematical questions. For instance, 'how do we cure cancer?' is a complex question with no answer at present, but we do know the method for answering it: through medical science. For philosophical questions, the method for answering that question is not obvious. So while 'what is health?', for instance, can be treated as a scientific question and approached from a medical or psychological perspective, it can also be treated as a philosophical question. When it is treated as a philosophical question, as we do with the questions in this volume, we often start with questioning assumptions or presuppositions related to the issue.

In the health professions, we often admit to enjoying clarity and certainty—being able to definitively diagnose someone's undifferentiated illness, discussing likely treatment outcomes, knowing exactly how to analyse a set of qualitative data, perhaps even knowing the path for most effective instruction of healthcare learners. A lack of consensus regarding what philosophy 'is' may be unnerving for some. But yet another way of seeing philosophy is that it is primarily a *practice*, and that what this practice is, exactly, is to be discovered in practicing it. In this case, this means reading through the various chapters in this book and using them in a dialogue with your everyday practice in the health professions, whether you are a teacher, trainee, researcher or programme director. In lieu of being able to offer certainty, we would encourage you to sit with, become familiar with, and eventually embrace this ambiguity, and the ambiguity that will, without doubt, be brought to the fore of your experience as you read this book (more about ambiguity later in Chapter 21).

There are different ways of thinking about the question of what philosophy 'is'. In this book, we will try to do justice to this diversity, but our perspective is by no means definitive, or even universally applicable. Certainly, philosophy involves the study of fundamental questions (such as "What is health?", "What is illness?"), but it defies classification as a field or discipline (there is an academic discipline of philosophy, but this alone is not philosophy in its entirety). It is more of an approach, an openness to asking questions about our thoughts and practice and is more concerned with asking questions than necessarily being able to answer them (Midgley 2018). It is thinking about things we may not usually think about, and critically, at that (Raphael 1994). Whereas educational theory offers explanations—narratives or models of the world—philosophy is more of an activity, a questioning of one's assumptions in order to find coherence in the chaos without becoming too rigid. Even without necessarily providing answers or explanations, like a theory might, asking questions is powerful, as questioning established ideas, practices, attitudes, and institutions opens a space for discussion and reflection that can lead to progress (Buckingham 2011). Simply put, as you read this book, philosophy happens in how you take the book and use it to examine and question your own practice.

Before we introduce you to our thoughts regarding why we need philosophy, and particularly this project of moving towards a sort of philosophical praxis—an applied philosophy—for health professions education, we should also consider why

philosophy matters. Why, as Galen suggests in the quote that heads this chapter, is the best physician (or healthcare professional), also a philosopher?

Firstly, living well is important for our own flourishing, and in promoting and enabling the flourishing of others (Wilson 1986). In order to understand how to live well—how to think and act in accordance with reason—readers must be able to make sense of philosophy. This is not just a case of understanding the language philosophers use (though there are many philosophical texts that are densely written), but also a case of appreciating how the message contained in that text should influence one's thoughts or actions in the world. In health professions education, you will perhaps be most familiar with philosophy as a lens through which to consider ethical practice and decision-making as a clinician (see Chapter 24 for more on contemporary ethics education). Whilst valuable (we have included a chapter on this topic and think most would agree that healthcare professionals should practice 'ethically'), instructing healthcare students in philosophy is not the only way in which we can philosophise our field. We must think more broadly as to how philosophy might meaningfully influence our educational practice and research.

In Chapter 2, Pols and Berding suggest that the health professions "need philosophy as a clarifying and 'meaning-producing' discipline". We agree and would add that this need has been overlooked. Although health professions education is frequently touted as being 'interdisciplinary', the field is increasingly limited through its failure to meaningfully engage with wider discourse, such as that within philosophy. Indeed, research and pedagogical strategy within health professions education is increasingly monodisciplinary, drawing most frequently on theories developed for use specifically within health professions education (Laskowski-Jones 2016; Allen et al. 2006; Rotgans 2012; Hautz et al. 2016; Paton et al. 2020). This is concerning, as transdisciplinary research has been shown to more readily address complex social issues, and transdisciplinary education produces healthcare graduates who are better prepared for the collaborative, interprofessional reality of medical practice (Morley and Cashel 2017; O'Sullivan et al. 2010).

The transdisciplinary and practical application of philosophical concepts directly to contemporary issues within health professions education may yield new insight. Although some contemporary issues within the field are relatively recent in inception, such as the desire to produce trainees with high levels of 'tolerance of ambiguity', some issues have persisted for decades, such as inequality, and medicine's burnout epidemic. The field has wrestled, or continues to wrestle, with these issues whilst often affecting little practical progress or change. Indeed, Kahlke et al. (2020) note that there is often a disconnect between 'knowing and doing' in health professions education. In this book, we explore, explain, and apply philosophical concepts to contemporary issues or areas of interest within health professions education to help educators think about the structure and dynamics of said issues. As Midgley (2018) suggests, philosophy is:

> all about how to think in difficult cases – how to imagine, how to visualise and conceive and describe this confusing world… in a way that will make it more intelligible as a whole. (50)

In other words, not only is philosophy "thinking about thinking" (Honderich 1995), but it is particularly so in regard to difficult cases that promote an understanding that acts as a basis for action. As a practically pitched overview, we hope you will agree that this book offers an accessible entry-point to philosophy for health professions practitioners, educators and researchers—translating "knowing" to "doing". This is what we mean by applied philosophy—it is a bridge between the practical concerns of health professions education as an educational field, and the broader, more conceptual and foundational questions that flow beneath the surface of all we do. As with building a physical bridge, our metaphorical bridge building will take time, resources, and collaboration. Though this book begins a conversation, it lays only the foundations for the bridge's construction. An applied philosophy for health professions education is very much in its infancy, though we hope this book is a starting point in progressing this type of thinking about thinking. To begin to build a bridge between practice and philosophical concepts in our field, in this book we offer insight regarding how to think about difficult cases or topics the field has struggled with. In doing so, we focus on the practicality or *praxis* of philosophy to research and educational strategy within the field, offering guidance regarding how to manage the transition from philosophical reflections to practical pedagogy.

This book is not exhaustive. Whilst, as discussed, herein we lay the foundations for a bridge between philosophical concepts and practice within health professions education, there is much beyond these initial building blocks that we could have included. Our selection inevitably reflects our own backgrounds, experiences, and perspectives. Though we aim to speak to the field of health professions education (and, indeed, have endeavoured throughout to make clear applications that we believe transcend professional boundaries), all three editors are most closely associated with medical education. In addition, all three editors are based in the Western hemisphere. This book, perhaps, would be best framed as an applied philosophy for Western medical education. We hope further articles, books, and volumes, may explore application and different philosophical approaches relevant to non-Western settings. In selecting our chapter topics, we considered the field of health professions education, discussing where we saw there to be gaps or 'absences' (Paton et al. 2020) which might benefit from exploration through philosophical lenses. For example, Chapter 16 considers 'Green Bioethics', applying bioethics to the issue of climate change and planetary health within health professions education. Bioethics is much broader than this, as the chapter author Richie demonstrates through her historical overview of bioethics at the beginning of the chapter. Yet, we perceived climate change and climate change education as outstanding and urgent issues in our field that might benefit from thorough dissection from a bioethics standpoint. Others may see different gaps or absences than we have—we welcome such discussions, as it is this type of critical engagement that will advance our plight for an applied philosophy for health professions education. As you read, we encourage you to reflect on whether you agree with the gaps or absences we have identified and solicited chapters to consider. If not, what would you do differently, or add? Tell us—engage the health professions community with your thoughts of applied philosophy for the gaps *you* see. This is how we can generate new philosophical ideas in our field.

This book is a journey towards mutual understanding. By this we mean the drawing together of students, practitioners, educators, researchers, and philosophers to develop a new way of thinking about contemporary issues within health professions education. We have tried to balance these voices within each chapter, creating author teams with varied backgrounds, experiences, and practice. In doing so, each chapter constitutes a conversation between the theoretical and the practical from those engaged in this dialogue. As you will see, some chapters are more conceptual in nature, as they are concerned with offering overviews of whole disciplines of practice and knowledge (e.g., Chapter 17 considers the Philosophy of Technology), whereas some chapters lean more towards application (e.g., Chapter 19, which applies insights from Chapter 17 to the sticky technological issue of social media).

Though the structure of each chapter varies—some include case studies, others offer a historical timeline of philosophy as it pertains to a particular focus or area of study—each chapter is structured so that it concludes with five practice points for practitioners, educators, and researchers. These practice points represent the culmination of our attempt at creating an applied philosophy for health professions education based on the more conceptual, theoretical, or historical explorations embedded in each chapter. We would encourage readers to pause and reflect on the potential significance of these practice points to their own day-to-day work as practitioners, educators, or researchers. We hope, through such reflection, you find use for our authors' recommendations. In doing so, we, as a community, enact the 'applied' part of our applied philosophy for health professions education. Without your action, the applied philosophy that has begun to take shape through this volume remains illusory.

You may read this book as you see fit, but, as editors, we have some suggestions as to how might approach this volume. For those seeking in-depth immersion in applied philosophy for health professions education, we suggest you read this book in chronological order. Instead of grouping the chapters by topic or philosophical approach, we have intentionally grouped them in a kind of narrative, or journey, that we hope to be supportive of a question or area of interest that you may have in relation to health professions education. We will show an example of how one could take an issue such as 'autonomy' through the chapters in Chapter 25 where we offer our concluding thoughts. We hope that this suggestion of choosing one or more areas of your own interest and reading the chapters in order with that in mind will offer new philosophical and practical angles on what matters most to you in your profession or education.

We speculate this approach may be most appropriate for postgraduate students in health professions education research e.g., Master's level and PhD students. You may not have the time to dedicate to reading the book in this way. Indeed, there may only be a select few chapters you believe to be relevant to your practice (though we would suggest that you may find chapters you thought were not strictly relevant to your practice may help you look at your practice in unique and surprising ways). For those with less time or a specific focus, each chapter may also be read in isolation, though, as you read, it will become apparent that many of the chapters in this book are connected. Even if you are only interested in learning more about applied philosophy

as it pertains to, say, social justice within health professions education (Chapter 9), you would be best placed at least also reading the chapters which connect to your primary chapter of interest. We have signposted these connections in the text of each chapter.

We would like to conclude our introduction with another quote from Midgley that we hope you will take as a guiding light in reading this volume. Below, Midgley compares philosophy to plumbing to stress its necessity and inherent practicability. As you read this book, we encourage you to picture philosophy and its need in our field thusly:

> Is philosophy like plumbing? I have made this comparison a number of times when I have wanted to stress that philosophising is not just grand and elegant and difficult, but is also needed. It is not optional… Plumbing and philosophy are both activities that arise because elaborate cultures like ours have, beneath their surface, a fairly complex system which is usually unnoticed, but which sometimes goes wrong. In both cases, this can have serious consequences. Each system supplies vital needs for those who live above it… conceptual confusion is deadly, and a great deal of it afflicts our everyday life. (139–142)

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Chapter 2
Philosophy of Education: Towards a Practical Philosophy of Educational Practice

Wouter Pols and Joop Berding

2.1 Introduction

Like health care, education is not a *thing*, but an *activity*. Educational activities take place within institutional frameworks of practices, such as schools, day care centres, children's homes, youth clubs, and families. But what does 'educational practice' mean? It is a practice of child rearing, upbringing, and teaching in which educators interact with children and young people with the intention of helping them grow up. Growing up is not so much attaining an adult status, but concerns becoming acquainted with the world in which one lives and taking responsibility for what one does in that world. Taking responsibility is not an activity that can be produced in a child or adolescent by an educator, and neither can that child's activity of becoming acquainted with the world. An educator can help children and young people to attain these activities—they can show them how to do it, invite them to act, but they cannot do it for them; children and young people must become acquitted with the world and take responsibility by themselves. Education always implies self-formation. Without the self-activity of children and young people, education can never succeed.

Nowadays, educational practices are informed by very different theories: psychological, sociological, economic, managerial theories, and so on (cf. Bartlett and Burton [2006] 2016). Education is no longer studied from a single angle; current educational practices are studied through a multidisciplinary lens. The theories that inform educational practice describe and explain the educational process from the perspective of the discipline they stand for. So, today, there are many descriptions and explanations of the processes that take place in the field of education. Within

W. Pols (✉) · J. Berding
Rotterdam University of Applied Sciences, Rotterdam, The Netherlands
e-mail: wouterpols1@gmail.com

J. Berding
e-mail: jwa.berding@ziggo.nl

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this multidisciplinary approach, there is one discipline that distinguishes itself from the other disciplines: philosophy of education.

Philosophy does not describe and explain processes as other disciplines that inform education do; it is not focused on the functioning of processes, on cause-and-effect relations. Instead of that it clarifies and tries to understand the *meaning* of education. The philosophical focus is a focus on concepts. The intention of philosophy is to open a field of thought through the concepts it develops. Philosophy of education presents concepts that allow child rearing, upbringing, and teaching to appear as an *educational* practice. This chapter deals with philosophy of education as a philosophy of educational practice.

In Sect. 2.2, we consider some examples of thinking regarding education in the history of philosophy, latterly describing the rise of philosophy of education in the last century. In Sect. 2.3, we give some examples of different philosophy of education positions, not only those with roots in the English-speaking world, but also from the non-English speaking world. Later, in Sect. 2.4, we focus on the practical philosophical concept of pedagogy as it was developed by the French educationalist Philippe Meirieu. Finally, in Sect. 2.5, we describe similarities between the educational and health professions, and the importance of a practical philosophy for these professions.

Before we progress further, there is something important we must clarify. Even though philosophy of education is about the education of children and not yet grown-up young people, certain views may be important for professionals working with grown-up students in health professions education. Where that is the case (particularly within Sect. 2.4), we will clearly highlight this applicability.

2.2 Philosophy and Education

Growing up is a social and cultural phenomenon. One needs fellow human beings to become a grown-up person, humans who point to, who show, who indicate the direction one should go, and help and support one in doing so.

When societies develop, people start to think about how this process of growing up should take place.

2.2.1 Plato and Aristotle on Education

In the Athenian society of the fifth and fourth century BCE, education was one of the topics of what the Athenians called philosophy, literally: desire (*philein*) for knowledge and wisdom (*sophia*). We find in the work of Plato (427–347 BCE) and Aristotle (384–322 BCE) several places where education is discussed. For both, politics and education are closely related. Plato was a more elitist philosopher than Aristotle. In his *The Republic*, he describes the education he wants to give to the best

among the young male Athenian citizens, the ones that are the best suited to it. The intention was that they would later lead the state. Aristotle, on the other hand, did not differentiate between the male citizens of Athens. All free male citizens should be able to achieve a happy and virtuous life. That life isn't a life in isolation, it is a life of togetherness, a life of acting together. This implies a crucial educational task with important political implications. A state where humans can reach their destination of a happy and virtuous life will be a strong state as it is a state supported by happy and virtuous people. Virtue requires a guideline. In his *Politics* Aristotle ([335/323 BCE] 1990) writes: "There are three things which make men good and virtuous; these are nature, habit and rational principle" (40). He states that these things must be in harmony with one another. To put them into harmony requires not only knowledge, but also wisdom; so, philosophy as the source of knowledge and wisdom provides the guideline, both in politics and education.

Nature, habit, and 'the rational principle' are the basis of education in ancient Greece. Educators have to consider the nature of the child they are educating, help them to develop good habits and, by helping them to master the essentials of Greek culture, to develop not only physically and musically, but also intellectually, and morally. In Greek education, the emphasis was on what the educator does. But the activities of the child or young person are rarely mentioned. There is only one exception: Plato's description of the dialogues Socrates had with Athenian citizens, including young men. Especially in the early dialogues, Socrates tests the ideas and beliefs of his interlocutor; by doing this, he challenges the young man he talks with to think for himself, or in other words: to put the—according to Plato, innate—rational principle into practice. Here comes into existence what we call *'self-activity'* today.

In the history of philosophy, it is a very long time before educators emphasize self-activity as a crucial educational act. The French writer Michel de Montaigne (1533–1592) does so in one of his *Essays* ('Of the Education of Children', [1580] 2007) , almost two thousand years later: "I would not have [the teacher] start everything and do all the talking but give his pupil a turn and listen to him" (55).

2.2.2 Rousseau and Kant on Education

The philosopher who really put self-activity in the spotlight was the Geneva-born Jean-Jacques Rousseau (1712–1778). In his philosophical novel, *Emile, or Education*, he describes the development of a young boy (Emile) into a grown-up man. The development seems automatic; Rousseau describes it as a natural process. Emile is all self-activity. He feels free; through the activities he undertakes freely, and the experiences gained, he develops. Rousseau ([1762] 1921) writes:

> Let [your pupil] always think he is master while you are really master… No doubt he ought only to do what he wants, but he ought to want to do nothing but what you want him to do (84–85).

Rousseau takes nature as a guideline for Emile's education, for him nature is the basis of what Aristotle called the rational principle. He organizes Emile's environment in such a way that he can develop naturally. The environment shapes his habits, and through what he undertakes and experiences, he masters the essentials of culture, he learns to read, to write, and to calculate, and to orient himself in time, place, and space. Subsequently, he becomes capable of distinguishing good and evil. He learns it all by himself, as a self-active young man, but it is Rousseau who encourages him to do so, by engaging him in situations that provoke all these learnings.

As is the case with Plato and Aristotle, for Rousseau, too, education and politics are closely related. A democratic society in which people can live as free citizens—Rousseau describes this society in his *The Social Contract*—, needs people who are educated as free humans. The *Emile* is the pedagogical counterpart of the political *The Social Contract*.

The great German philosopher Immanuel Kant (1724–1804) was impressed by the *Emile*. It is said that he forgot his daily walk when he was reading the book. Rousseau taught that humans are corrupted by society; on the other hand, Kant ([1784] 1963) said that they are made of 'crooked wood' out of which 'nothing perfectly straight can be built'. Humans are imperfect. They should be aware of that: they need to know what exactly they can know, must do, and may hope. That is why humans need education. Kant recognizes the importance of discipline; it can result in what the Greek called good habits, but discipline is not yet education. Education requires self-activity; its intention is to make free. Freedom does not mean doing what you want. Freedom requires the recognition of a super-individual, rational law to which humans measure their actions. That must be taught and can't be without restraint, Kant argues. In his lecture on education he states:

> One of the greatest problems of education is how to unite submission to the necessary, *restraint* with the child's capability of constraint moral exercising his *freewill* – for restraint is necessary. How am I to develop the sense of freedom in spite of the restraint? (Kant [1803] 1900, 27)

Rousseau hid this question behind the educational environment where Emile grew up. Kant made this question the crux of education.

Even when confronted with this major problem, Kant still expects a lot from education. He does not believe that by following the law of nature humans could improve themselves. Improving themselves, however, is a human's most important task. Kant hopes that generation after generation humanity will get better. In addition to this, education is not only the link between the generations, but also the lever for improvement. Cultivation, civilization, and moralization are the necessary steps to take in education. It is through the step of moralization that humans make themselves free. So, unlike Rousseau, it is not by following the law of nature within Kant's philosophy that frees humans, but the rational principle mentioned by Aristotle, long ago.

2.2.3 Dewey on Education

For Kant, the older generation's task is to educate the younger in such a way that they could become cultivated and civilized, but, above all, become moral and free humans. One could say that education is a certain kind of intergenerational communication. The North American philosopher John Dewey (1859–1952) would agree (for detail on Dewey's other work see Chapter 17, which considers Dewey's pragmatist philosophy of technology). One hundred and thirty years after Kant's lectures, he writes in his *Democracy and Education* ([1916] 1966) "all communication is educative" (5). Dewey considers the cultural processes that take place between people as a process of interaction. In such a process, mutual adjustments take place. Such adjustments lead to shared experiences. For Dewey, these experiences are crucial; they not only bring people together, but also create a common world. He writes: "Communication is a process of sharing experience till it becomes a common possession. It modifies the disposition of both the parties who partake in it" (9). What Kant calls cultivation, civilization, and moralization are nothing but different forms of communication. These super-individual forms, which could be compared with Kant's super-individual, rational law cannot exist without the self-activity of the participants—of the educator, but foremost of the one who is educated: the child or adolescent: "Education is not an affair of 'telling' and being told, but an active and constructive process" (38). Such a process allows children and young people to break their habits, acquire new knowledge and skills, and relate to their fellow human beings in a new way, perhaps a morally more considered way. We speculate the same may be true of educators invested in this process.

Aristotle considered nature, habit, and reason (the rational principle) as the crucial elements of education. We conclude that he was right. In the history of educational thinking those core elements appear in new configurations time and time again.

2.3 The Rise of Philosophy of Education

In the Western world, whilst the importance of education increased in the nineteenth century it truly amplified in the 20th. Education Acts were introduced, new schools were set up, teacher training was improved, and the first chairs of pedagogy were established at universities.

2.3.1 Pestalozzi, Herbart, and a Practice-Based School Pedagogy

The educational ideas that had developed over centuries and were given new forms in the second part of the eighteenth century, spread across Europe and North America.

The German-speaking countries played a major role in this. In Switzerland, Johann Heinrich Pestalozzi (1746–1827) developed a pedagogy focused on head, heart, and hand aiming "to forge oneself through his own work" (Pestalozzi [1797] 1968, 98). He was inspired by Rousseau; he wrote about education, but besides his writing he set up different educational institutions where he put his pedagogy into practice. In Germany, Johann Friedrich Herbart (1776–1841) developed—partly in discussion with Kant—a 'pedagogical science', twenty years later. Herbart met Pestalozzi in Switzerland. There, he started as a tutor, but soon he went back to his homeland and became a professor in philosophy and pedagogy. The purpose of education was, according to him, to form a moral and many-sided character. To this end, education must provide the right mental representations, both in culture and nature. Pestalozzi's and Herbart's ideas became the leading pedagogical ideas in the nineteenth century, over Europe and North America, the former in the first part of the century, the latter in the second.

At the end of the nineteenth century, a movement of educational renewal emerged, emphasizing child's activity, aimed at gaining and sharing culturally determined experiences. Many people, practicians, and theoreticians joined this movement. Dewey, who put his ideas into practice in his Laboratory School, was one of them. All those ideas entered the school, through training, through individual teachers who tried to change school practice, and through newly established schools that put a new pedagogy into practice. It led to several new practice-based school pedagogies.

2.3.2 The 20th Century and the Rise of Philosophy of Education

The twentieth century brought new changes. Compulsory education was introduced throughout the Western world. Education became a human right. Over the century education was gradually extended, becoming longer and longer. New social sciences such as psychology, sociology, economics emerged that started to investigate human activities, including educational activities. Contrary to philosophy, they did not focus on the meaning and purpose of the activities, but on the functioning of the processes that would determine them. During the twentieth century, education increased in importance. Now, school was important not only for the intellectual and moral development of new generations, but for the development of a country's economy. Policy makers began to emphasize learning outcomes. As a result, teachers were subjected to ever higher demands. No longer were they trained at normal schools or stand-alone teacher colleges, but at universities. There, they were introduced to the results of the now emerged social sciences. These sciences began to prescribe certain approaches, stating that certain skills were necessary to obtain desired outcomes. The image of practice was no longer determined by a practice-based school pedagogy, but by a multidisciplinary field of research results that provided prospective teachers with the necessary knowledge and skills to act as able educational professionals.

The contribution of the social sciences to teacher education provided a new view, not only of educational practice, but also of the teacher within this practice. The social sciences describe how development and learning processes proceed, how such processes can best be managed and what resources can be used to achieve certain goals. But they do not describe the educational *meanings* of what one is doing, the educational aims one pursues, what is at stake when one is teaching. The social sciences cannot do that; *philosophy* can do it. With the rise of the social sciences within the field of education a new branch of philosophy arose named philosophy of education. In the English-speaking countries this new branch focused initially on clarifying the concepts used in the educational field: 'education', 'development', 'curriculum', 'teaching', and so on (cf. Hirst and Peters 1970). The method used was that of language analysis. But soon, concepts of philosophy were used to shed new light on educational processes. In the 1960s, one of the most prominent philosophers of education in the English-speaking world, Richard Peters (1919–2011), introduced Ludwig Wittgenstein's (1889–1951) concept of initiation into the philosophy of education. Following him, he stated that "education… has to be described as initiation into activities or modes of thought and conduct that are worthwhile…" (Peters [1966] 1970, 55). Concepts of other philosophers were also introduced: concepts of Hannah Arendt (1906–1975), Emmanuel Levinas (1906–1995), Jacques Rancière (1940), and many others. Arendt enriched the philosophy of education with the concept of 'to introduce into the world', Levinas with 'the face of the Other', and Rancière with 'the equality of intelligence'. Each of these concepts sheds new light on education, but by doing so, it also calls into question existing educational practices. Nowadays, philosophy is no longer just a clarifying and 'meaning-producing' discipline; it also is a critical discipline. Its intention is more and more to encourage us to start 'thinking again' (Blake et al. 1998), aimed not only at prospective teachers, but at everyone involved in education, teachers in practice, managers, and policy makers.

2.3.3 The Intellectual 'Home': Discipline or Educational Practice?

Today, philosophy of education is an important discipline within the field of sciences that deal with education. It is a discipline with its own voice: a critical voice aiming at meaning and purposes. From different philosophical perspectives, it focuses not only on various educational target areas, but also on the different parts of the broad field of contemporary education (Blake et al 2003; Siegel 2009; Smeyers 2018). Despite the large differences between sciences dealing with education and philosophy of education, there is also a similarity: the intellectual 'home'. This home is the discipline, for instance psychology, sociology, or economics, and—concerning philosophy of education—philosophy (Biesta 2012). The home is not the practice of education. The practice is the object of study, the object investigated by different sciences and to which philosophy applies its concepts. It is approached from the outside, and not

approached as a practice with its own 'dignity', a practice with inherent meanings, purposes, and principles.

However, there are exceptions to the above-described dominant view. Even in English-speaking countries where this is particularly the case, there are exceptions, for example the work of the North American David Hansen (1952). Contrary to the dominant view, the 'home' from which Hansen departs is not that of philosophy, that of the discipline, but that of educational practice. So does the Dutch-born Gert Biesta (1957). Hansen's starting point for his reflections on education is what teaching means for teachers and the goals they pursue in educational practice (cf. Hansen 1995); and Biesta's starting point for thinking through the concepts he uses—concepts he derives from various philosophical resources—is also, like Hansen, the inherent meaning and purpose of educational practice (cf. Biesta 2014). There are more exceptions to this dominant view, notably in the German-speaking countries and in several neighbouring countries, like Scandinavia, the Netherlands, Belgium, and France (Biesta 2011).

2.3.4 Pedagogy as Part of the Humanities

As we have seen, Germany played an important role in spreading pedagogical ideas in the nineteenth century. This was not only done by newly established educational institutions where innovative practices took place, but also by universities. In Germany, the first chair of pedagogy was established in 1778, in Halle. Herbart was a professor in philosophy but also in pedagogy, from 1802, first in Göttingen, later in Königsberg. He gave lectures on pedagogy, but also acted as teacher educator in the experimental school that was affiliated with the university. In Germany, educational theory and educational practice were closely related from the beginning. Pedagogy (in German: *Pädagogik*) means not only the theory of education, but also the *practice* of it. Pedagogy as it developed in Germany from the end of the nineteenth century, uses, as part of the humanities, philosophical methods (phenomenology and hermeneutics) to investigate educational practice. Even though the influence of social sciences in educational research dominates nowadays, the philosophical inspired, humanities research approach to the study of education remained in Germany, and in some other countries as well.

After the Second World War, a phenomenology-based pedagogy was developed in Germany and the Netherlands. The Dutch educationalist Martinus Langeveld (1905–1989) states in his *Beknopte theoretische pedagogiek* [*Concise Theoretical Pedagogy*] ([1945] 1971):

> We wish to analyze [the educational] phenomenon only as such for now. We do want to interpret it from another source than from itself… we start in a phenomenological way (29).

Langeveld starts his investigation from educational practice itself, from the experiences of the educators in the educational field and the ones they educate. By investigating these experiences in a phenomenological way, unprejudiced, he achieves

insight in what education is all about: bringing children and young people to grown-up-ness, but at the same time considering their desire to be someone themselves. Although phenomenological pedagogy disappeared in the Netherlands after the 1990s, it persisted in Germany, where it has flourished in recent years (cf. Brinkmann et al. 2017). By way of the Dutch-born Max van Manen (1942), it was spread in Canada and the United States (Van Manen 2015; Friesen et al. 2012).

The hermeneutic-based pedagogy also persisted in Germany. In his *Forgotten Connections* (2014), translated into English, Klaus Mollenhauer (1928–1998) investigates the 'becoming' of current educational practices. Using pictures, all kinds of texts, including experiences put in writing, he reconstructs the basic structure of educational practice. According to him, this structure consists of two pairings: the first of presentation and representation, the second of *Bildsamkeit* and self-activity. The first has to do with the fact that educating implies becoming acquainted with the world. To achieve grown-up-ness, children and young people need educators who show them the world. This can be done directly by presentation and indirectly by representation, through artifacts and symbols. The second concerns the educator's view of the child. Only if the educator considers children and young people as *bildsam*, as humans that have the capacity to form themselves, and challenges them as self-active humans to do so, can they achieve grown-up-ness. Langeveld would entirely agree.

German pedagogy considers theory and practice as closely linked. In education, practice cannot exist without theory, neither theory without practice. Educational practices are cultural-historical practices where theories and practices continuously influence each other. We still find ways of doing and thinking from the past in current practices. The question is what educators today find worthwhile. In what way do they intend to continue the historically grown practice? Mollenhauer (2014) writes:

> Children should be brought up *not* as if they were [simply] material to be changed and formed. Instead, they should be raised in support of a kind of power and potentiality that develops itself, in a dialogical relationship, in a kind of mutual interchange or call and response (93).

2.4 Philosophy of Education as a Theory of Practice: Meirieu's View

In Herbart's first lecture in 1802, he makes a remarkable statement: "First, let's distinguish pedagogy as science from the art of upbringing' (Herbart [1802–1832] 1986, 55). Science as theory is general, practice is individual. That is why theory is always "too much and at the same time too little" (ibidem). There is a gap between the more general theory and the more individual practice. According to Herbart, practice needs 'tact'; this can only be achieved by doing and reflecting on what one does in practice. That's not saying theory is not important. It is important, in preparation for practice and reflection on practice. In the introduction of his *Allgemeine Pädagogik* [*General Pedagogy*] from 1806, Herbart speaks about theory as a map. The map

allows the educator to determine their direction, but also helps them find the way they want to go and to reflect on the results of it.

2.4.1 Meirieu's Pedagogy as a Map

The French educationalist Philippe Meirieu (1949) affirms Herbart's stance of pedagogy as a map. For him, pedagogy is an 'educational doctrine' that consists of loose, heterogeneous elements, "a number of reflections and ideas" that enable the educator "to take on a pedagogical challenge" (Meirieu 2004, 136). Pedagogy is a practical theory, an 'in-between theory', between sciences and philosophy on the one hand, and on the other hand practice, and the experiences gained there. It is, indeed, a map to orient on educational practice, and to reflect on the gained experiences.

At the most basic level, educators should make the map by themselves. The starting point of the map is not science, nor philosophy; it is practice, more precisely: the resistance of the child or adolescent that the educator experiences. Meirieu speaks about 'a pedagogical moment'. According to him, the heart of such a moment is resistance; it's the moment that the educator experiences that a child or adolescent escapes their power (Meirieu 1995). The child or young person has their own will. During such a moment, the educator experiences that children and young people aren't objects; they are subjects; they have, as Langeveld said, the desire to be someone themselves. That is an experience-based, pedagogical fact. But that fact does not absolve the educator of the responsibility to introduce children and young people into the world and help and support them as self-active young humans to grow up, and achieve grown-up-ness.

In his *Le choix d'éduquer* [*The Choice to Educate*] (1991), Meirieu states that the act of education is based on a choice. It is a choice for the child as subject. In education, the crucial question is always: "Do I allow the other, the one in front of me, to be a subject, even if it goes against me?" (12). For Meirieu, the educator is able to say 'yes' to this question because they believe in a child's educability. They does so, because they are convinced of the child's inherent capability to form themselves, convinced of what the Germans call *Bildsamkeit*. Based on this conviction, Meirieu argues that the fundamental task the educator stands for is twofold: to call the child as subject into presence, and to provide them with the cultural tools, and help to use them, to be able to inhabit the world in which they live.

A teacher, who is always an educator as well, can only accomplish this task within an educational safe space. A school should be a safe place where children and young people can communicate and gain experiences with the cultural tools they are offered. Safety requires a law to which all participants measure their actions. This law functions as a 'third party' and positions one against the other. Within such a safe space children and young people can appear as subjects and learn to work with the cultural tools offered them. At the same time, it is a place where they learn to live together. School is a form of community life, as Dewey said, a mini society where

citizenship is learned (Meirieu 2004). The other fundamental task of an educator or teacher, respectively, is to install such a safe place, a safe mini society.

Here we can learn lessons for the education of health professionals. Here too, self-activity and confidence in the student's *Bildsamkeit* is crucial. Only if the health care student is addressed as a subject, is challenged as a subject to pick up medical tools and challenged to work with them, can they become a responsible health professional. That is only possible if the place in which health professions education takes place is a safe place in which students can make mistakes and can learn from their mistakes. The place where health care education takes place should be a place of professional togetherness, a place where the professional attitude of healthcare workers is put into practice daily, by professional health professions educators firstly, and, following their educators, by students.

2.4.2 A Situated Philosophy

Back to Meirieu's pedagogy. The pedagogy he puts into practice can be called a "situated philosophy" (Burbules 2018, 1424). It is a practical philosophy. Like philosophy of education, it generates meanings and indicates purposes. Above all, however, it is a practical philosophy through the concepts it proposes; these concepts make practice appear as an *educational* practice that challenges the educator to act. Meirieu's practical philosophy does not give clues and hints, it points, from the concepts presented, in a direction, ways to go, to special points to notice, to obstacles to overcome. It is indeed a map, a map to orient oneself, to determine one's direction, to find one's way, to help to make decisions.

You may have noticed that Meirieu's practical philosophy is part of a long-standing philosophical and pedagogical tradition. Concepts of many philosophers and pedagogues can be found in it. They form a loose network together; they are the conceptual crossroads on a pedagogical map. For example, self-activity, *Bildsamkeit,* and the law as 'third party'. All kinds of other forms of knowledge, practical and theoretical, can be connected to it. Meirieu does so, but he also challenges the user to do it themselves. And that is indeed also an educational task: to elaborate the maps educators are working with based on the experience they are gaining in the educational field.

2.5 Some Final Remarks on the Similarities Between the Healthcare and Educational Professions

Despite differences in training and work, there are striking similarities between the health and educational professions. Both professions exist by the grace of relationship. Health professionals such as doctors, nurses, and therapists work with

Table 2.1 Practice points

	Health professions educators should be aware of the importance of:
1	Philosophy within health sciences
2	'Situated philosophy' as orientation aid (map) to professionals in health care practice
3	Trust in students' capability to form themselves
4	Self-activity
5	A safe place to be educated in

people, that is also the case with educational professionals such as teachers, child-care workers, and coaches. Both professions are informed by a wide field of scientific disciplines. Today, both the practice of health care and education are viewed through a multidisciplinary lens. However, sciences describe and explain, but do not describe the *meaning* of what takes place in healthcare practices, nor what the ultimate purpose of it is. Education pursues grown-up-ness, health care pursues health. But what do these terms mean? Science can't answer this, but philosophy can. That is why within the field of health professionals—as with the educational professionals—science needs to be supplemented with philosophy. But don't they need a practical philosophy as well? A situated philosophy of healthcare situations? Don't doctors, nurses, and therapists need maps, too? Maps to orient themselves, to determine their direction, to find their way, to help to make decisions.

Further, what of the healthcare professional who educates prospective healthcare professionals? What else can they learn from philosophy of education? To reiterate our earlier discussion, we believe that they may learn the importance of trust in a student's capability to form themselves, the importance of self-activity, and of a safe place to be educated in (Table 2.1).

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Chapter 3
Subjectification in Health Professions Education: Why We Should Look Beyond the Idea of Professional Identity Formation

Simon Verwer and Marije van Braak

3.1 Introduction

The relation between teaching and learning in health professions education is a complex one. Thinking about health professions education from an educational-philosophical outlook in a recent article, Biesta and van Braak (2020) critiqued what they called a common way of thinking about health professions education: *teaching* as an intervention that causes *learning*. The article's central argument that health professions education, and, more specifically, medical education (still) (too much) relies on this assumed causal relation between teaching and learning, has induced many reactions in the field. Medical teachers and researchers across different disciplines have stated that this is not (anymore) an accurate description of how the field views teaching and learning.[1] Yet, in health professions education literature, the discourse that we use to describe teaching points in the contrary direction. For one, the way we construct and research curricula (in terms of learning goals, related key activities, and how teachers can contribute to those), shows how interrelated teaching and learning are assumed to be. Further, although health professions education research may have moved away from linear notions of causality, in practice, 'evidence-based' still functions as a marker of quality which drives curricula towards somewhat generalized assumptions about how education 'works'.

[1] Interested readers can tune in to the discussion, at https://keylimepodcast.libsyn.com/episode-298 and https://twitter.com/MarioVeen/status/1353974383128289280?s=20.

S. Verwer (✉)
Amsterdam UMC, Amsterdam, The Netherlands
e-mail: s.verwer@amsterdamumc.nl

M. van Braak
Erasmus Medical Centre, Rotterdam, The Netherlands
e-mail: m.vanbraak@erasmusmc.nl

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These descriptions of health professions education correspond to what the educationalist Gert Biesta has described as *learnification* (Biesta 2010):

> …the redefinition of all things educational in terms of learning – such as calling students learners, calling schools learning environments or places for learning, referring to adult education as lifelong learning, and seeing teachers as facilitators of learning. (Biesta 2019, 549)[2]

In short, learnification is the refocusing of education from teachers and the curriculum to learners and their learning (Biesta 2020b).

A conceptual area within health professions education where learnification becomes visible is that of Professional Identity Formation (PIF). PIF is a well-researched and commonly applied concept that describes the process of becoming a healthcare professional, such as a doctor, i.e., developing a professional identity. The use of PIF in health professions education is tied to the dominance of the language of learning: it entails a focus on what the learner needs to do, experience, and develop to become an established member in the field of practice (e.g., Cruess et al. 2019). This focus may have diverted attention from other concepts that describe aspects of a person's formation as a professional.

In this chapter, we focus on one such concept: subjectification. Subjectification is one of the domains of purpose proposed by Biesta and van Braak in their alternative view of health professions education. It describes the process of appearing as a subject (Biesta 2010)—an utterly relevant process in the context of formation of a professional self, since it draws attention to the subjectivity of the person whose professional identity is formed. In the following sections, we will explore the relation between PIF and subjectification, and describe how subjectification can be of additional value in health professions education. To do so, we first formulate a consensus about PIF in the current health professions education literature. Next, we argue why medical educators might want to look beyond PIF towards subjectification by contrasting the concepts in three respects: (1) as different approaches to the matter of existence (psychological versus philosophical); (2) in their relation to socialisation as a domain of educational purpose (part of versus addition to); and (3) the relation to the self involved in the concepts (who I am versus how I exist). We conclude the discussion with several suggestions for health professions educators and health professions education researchers.

[2] On potential reasons for this development, Biesta writes: "Although the learnification of contemporary education comes out of a number of different, only partially related developments (for a discussion see Biesta 2010), it partly stems from the suggestion that teaching limits the freedom of students whereas learning provides opportunities for students to be free and enact their freedom outside of the control of the teacher. That is why teaching—and quite often we nowadays hear 'traditional teaching'—is seen as problematic, outdated and 'of the past,' whereas learning is seen as contemporary and 'of the future'" (Biesta 2019, 550).

3.2 Consensus About PIF in Health Professions Education

PIF research within health professions education investigates "the process through which physicians acquire their professional identities" (Cruess et al. 2014, 1446). The concept, sometimes also referred to as *professional identity development*, was discussed in the context of health professions education as early as 1957 (Merton 1957) and is firmly rooted in broader developmental theories that have received much attention in educational and pedagogical research traditions (see Cruess et al. 2014 for an overview). Involvement with the concept in the field of health professions education has spiked in the past decade (Cruess et al. 2019). A much-used definition of PIF is the process of achieving a "representation of self" which is an internalization of "the characteristics, values, and norms of the medical profession, resulting in an individual thinking, acting, and feeling like a physician: think, act, and feel like a physician" (Cruess et al. 2014, 1447). In general, PIF in the health professions education field is understood to be a process of *socialisation*, a process of 'growing into the profession' (see e.g., Jarvis-Selinger et al. 2012; Wald et al. 2015). The profession recognizably represents norms, values, and ways of being and doing, by which established members of the profession can be recognized as representatives of that profession. Rather than having *control* over this process, however, health professions education is seen as providing the *context* in which the process is situated. Medical educators' jobs are facilitative to this end, they must help students "form, and successfully integrate their professional selves into their multiple identities" (Goldie 2012, e641; Rees and Monrouxe 2018).

In the educator's task to facilitate PIF, we see a dual focus: development of the self at the level of the individual (psychologically), and development of the self at the collective level (becoming part of social structures) (Jarvis-Selinger et al. 2012; Sawatsky et al. 2020; Wald et al. 2015). This duality could be described as a core challenge of PIF—PIF is about finding a balance between personal and professional identities in a normative context that includes dynamic interactions between both (Cruess et al. 2014; Holden et al. 2012; see also Beijaard et al. 2004, on professional identity formation in general education context). Finding that balance is a negotiation process that can result in "identity dissonance", that is, a situation in which professional identities are discordant with personal identities (Monrouxe 2010, 42; Costello 2005). Once this balance is achieved, however, professionals move from 'doing' to 'being', inching closer towards full participation[3] in their healthcare community of practice (Cruess et al. 2014).

Currently, we notice that research on PIF within health professions education most often assumes one of two related orientations. Firstly, some research focuses on the unique individuality of those who are becoming part of a healthcare profession.

[3] In situated learning theory, *legitimate peripheral participation* refers to "the particular mode of engagement of a learner who participates in the actual practice of an expert, but only to a limited degree and with limited responsibility of the ultimate product as a whole" (Lave and Wenger 1991 14). Members of a profession, according to this theory, develop from legitimate peripheral participation to full participation as they gain experience in the profession.

Cruess et al. (2015) describe the individuality of that process in terms of a multitude of influences that impact the process differently for different people:

> Multiple factors within and outside of the educational system affect the formation of an individual's professional identity. Each learner reacts to different factors in her or his own fashion, with the anticipated outcome being the emergence of a professional identity. (718)

The diversity in factors and responses to factors described in this quote makes fostering PIF in health professions education difficult—what should we focus on facilitating, what for, and with what effect? Sawatsky et al. (2020) provide some suggestions to that end. Their fundamental recommendation is to create space for openness and vulnerability, authenticity and diversity, weaknesses and feedback through positive role modelling. Wilson et al. (2013) also provide evidence for the importance of role modelling. Additionally, they describe how participation in communities of practice (which originates in *social* theory; Lave and Wenger 1991) and narrative reflection with peers also foster PIF. If identity is seen as a representation of the self, constructing and sharing stories relating to one's identity as a professional helps to form that identity in relation to other members' participation in that profession (Wilson et al. 2013).

The second orientation relates to the influence of the environment on the development of identities. Recent research from a constructionist viewpoint has focused on the *social* aspects of identity formation. This type of research draws attention to the way identities are co-constructed through interaction in social settings, enacted interactionally through language, and not limited to the realm of an individual's cognition (Monrouxe 2010; Monrouxe and Poole 2013; Monrouxe and Rees 2015). Although this second orientation indeed widens our perspective on the construct of identity from the individual to the collective, it still describes how an *individual's* identity is developed within a social setting.

In health professions education in general, the focus on personal growth of each individual (even beyond PIF) gets reduced to personal learning goals, lists of competencies, personal development plans, and core activities (see e.g., Sawatsky et al. 2020; Jarvis-Selinger et al. 2012). These are all examples of the language of *learning*: attention is foremostly given to who this specific *learner* is, what this specific *learner* needs, how this specific *learner* develops and how the teacher can contribute to that *learning*. Consequently, PIF-centred educational activities focus predominantly and excessively around the *autonomous individual*.

Now there's the rub.

Historically, education is a place that contributes to the way a person exists as a *free* person in the world (Biesta 2010). That is, education is more than the formation of an individual to fit in a prespecified professional mould. That is also to say that education is more than a handmaid to learning. It goes beyond learning, so to speak (Biesta 2006), in the sense that it creates room for more than learning alone. It creates room for a person *to exist in the world*.

To describe what it means to create room for a person to exist in the world, or, put differently, to describe education *in an educational manner*, we need a discourse

or language which is suited to 'deal with' teachers, learners, and the curriculum, and 'takes into account' the fact that we exist in the world (Biesta 2012a).[4] This discourse, Biesta argues (2010), centres around the question what education is *for*—its *purpose*.

3.3 Three Domains of Educational Purpose

What education is and what it is *for* are complex questions. Biesta has developed a series of ideas around notions of content, purpose, and relationships to deal with those questions in a constructive way. The starting point here is that the "language of learning is not sufficiently precise" because "the whole point of education (..) is not to ensure that students learn, but that they learn *something,* learn it *for a reason*, and learn it from *someone*" (Biesta and van Braak 2020, 450, italics in original). Having made the distinction between learning and education from an intentional, relational perspective, Biesta suggests three domains of educational purpose: qualification, socialisation, and subjectification. These domains of purpose can also be seen as functions of education (for an extensive discussion see Biesta 2010).

Qualification is the domain which includes the transfer of knowledge and skills: any education will be concerned with the question of what knowledge and skills should be made available and mastered by people taking part in that education. *Socialisation* concerns getting acquainted with a profession's ways of knowing and being, its norms and values. It is no question that becoming educated also involves interaction with a certain representation of what is considered valuable or not, in terms of behaviours and identities. The extent to which socialisation should be aimed for, however, can be questioned from the next domain. *Subjectification* is Biesta's third function or domain and is the focus of our discussion. In short, this domain draws attention to the observation that education is always concerned with the (im)possibilities of the individual and his or her capacities, for example in relation to questions around notions of freedom, emancipation, and responsibility.

An important point to stress here is the fact that these functions or domains can be separated from a theoretical, conceptual perspective, while in practice any educational activity affects these three domains at the same time. Whatever didactic model or activity is chosen (e.g., the more teacher-centred lecture or a student-centred lesson based on an problem-based inquiry approach), at any time, qualification, socialisation, and subjectification are happening, in a positive or negative sense. The relevance of these domains for health professions education specifically is in the way they provide a "precise discourse" that allows us to ask not whether participants in

[4] An interesting question for further research, which we will leave open for now, is how health professions education as a discipline is historically more closely related to the psychological research traditions than to pedagogy, and how this could account for the dominance of psychological perspectives on education in health professions education.

health professions education are learning, but "whether their education addresses all three domains of purpose" (Biesta and van Braak 2020, 451). In the context of health professions education, addressing the three domains of purpose entails that education "needs to aim for *professional qualification*, *professional socialisation*, and *professional subjectification* (Biesta and van Braak 2020, 452, italics in original).

Intuitively (as we have learned from interactions with medical educators in response to these domains), professional subjectification very much sounds like the formation of individuals within a professional community. Yet, professional subjectification and PIF are fundamentally different processes. In that sense, our introduction of professional subjectification in the next section is not meant to *replace* the concept of PIF. Rather, we present it as an *addendum*: why should medical educators look beyond PIF towards subjectification?

3.4 Professional Identity Formation and Subjectification

In what follows we will argue for the value of subjectification in addition to PIF by juxtaposing PIF and subjectification on three key points: (1) as different approaches to the matter of existence, (2) in their relation to socialisation as a domain of educational purpose, and (3) the concepts' relation to the self. A summary of these points is presented in Table 3.1.

We work from the assumption that "theory is crucial for the conceptualization of the phenomenon one wishes to investigate" (Biesta 2020a, 13) and approach theory as "*theory-as-a-specific-answer-to-a-specific-question*" rather than "*theory-as-truth"* (Biesta 2020a, 11). With that said, the specific question for our chapter could be articulated as: How can medical students not only *form* their identity as professionals but what can they *do* with it, and what does this ask from medical educators?

Table 3.1 Comparison of PIF and subjectification

	Professional identity formation	Subjectification
Approach to the matter of existence	Psychological	Philosophical
Relation to socialisation	Foremostly linked to socialisation	Different from socialisation
Relation to the self	3rd person perspective: *Who* am I?	1st person perspective: *How* do I exist?

3.4.1 PIF as a Psychological Concept Versus Subjectification as a Philosophical Concept

A first difference between PIF and subjectification seems to be their approach to the matter of existence. Traditionally, questions about the matter of existence belong to the domain of philosophy called ontology: the philosophical study of being in general (see Chapter 12 for a discussion on ontology in health professions education). Ontologists try to clarify what it may mean to speak about existence, becoming, and reality. As such, ontology is part of metaphysics.[5] Ontology and metaphysics have not been very present within the research tradition of health professions education which has been more related to psychology and sociology.[6]

The concept of subjectification, like its related terms subjectness and subjectivity, has not been used much in health professions educational literature.[7] As a concept, subjectification is notoriously hard to grasp. It is not our aim here to make a philosophical argument per se. What we do want to show is how approaching medical students from the specific philosophical background related to subjectification sparks a different kind of educational thinking, discourse, and practice. We will do so by presenting two short arguments.

The first argument is that subjectification implies that the subject is subject to their own existence. The fact that we exist in the world is an important given that we should not ignore, since it enables *and* limits our possibilities, both as educators and as human beings in general. Like the authors of Chapter 12 will later point out, it may be utterly helpful to move beyond the traditional focus on individual autonomy to an alternative ontology that focuses on the *relationships* between individuals. An explicit stance on how we exist means that relationships become the central focal point of an educational approach to education: to ask, 'how do I exist?' means also to ask, 'how do I relate to others, the world and also to myself?'. These types of questions are often asked by philosophers of education working from traditions like existentialism, pragmatism, hermeneutics, and phenomenology. What these approaches generally share is an explicit stand towards the matter of existence: human beings exist in the world—and that very existence in the world confronts us with a range of (educational) challenges.

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[5] Merrian-Webster dictionary defines metaphysics as a "division of philosophy that is concerned with the fundamental nature of reality and being and that includes ontology, cosmology, and often epistemology".

[6] It would be interesting to study in more depth how configuration of health professions education as an academic discipline has influenced the surfacing of certain concepts (for a reconstruction of the history of the discipline, see ten Cate 2021).

[7] An informal Google Scholar search in June 2021 using ["medical education" and "subjectification"] only yielded 429 hits, ["medical education" and "subjectness"] resulted in 28 hits, ["health professions education" and "subjectification"] in 25 hits, and ["health professions education" and "subjectness"] led to none. The combination of "medical education" or "health professions education" with "subjectivity" resulted in considerably more hits, but these mainly concerned bias-related meanings of subjectivity.

The notion of PIF does not so clearly provoke statements of how we exist or, put differently, where we exist, nor how existing in the world is an activity or engagement as such. Philosophically, PIF seems to focus more on epistemological questions such as how human beings construct meaning within social contexts. Questions on how knowledge—or identity—is or should be constructed are omnipresent, evident also in the many references to theories of learning as constructivism, cognitivism, and, more recently, constructionism (see Sect. 3.2), but ontological statements seem rather absent.

To better understand and to stress the importance of ontology in educational theory, we point to the notion of *resistance*. The notion of resistance could function as a clarifier between PIF and subjectification, as we will explain with an example. As subjects existing in a world, we experience resistance. We are not only actors, but also sufferers in the sense that we are subject to others and the world (Arendt 1958; Biesta 2014). This experience can be frustrating, since the world does not always listen to us, so to say.[8] Within the context of education, teachers experience resistance because students are free to make their own choices, which often do not align with what teachers have in mind for them. Students experience resistance when discovering that mastering certain subject matters challenges them to stay put and invest more time and energy than initially allocated. Approaching education from the standpoint of subjectification does not lessen the experience of resistance, as such, but reconfigures the relationship to it.

Giving meaning to resistance from the perspective of identity formation may not fully or less adequately capture the educational value of such experiences: identity, as such, does not tell us much about how to exist *in the world*. For education, this means that an educational purpose for health professions education should be to address the questions of existence, resistance, and frustration in a fruitful manner.[9]

The second argument for the introduction of subjectification instigating a different kind of educational thinking, discourse, and practice is the idea that existing as a subject is related to freedom, emancipation, and responsibility (Biesta 2014) in a way that identity is not. By approaching students-as-subjects, educators open up an *educational* view wherein students *can not* solely be *objects* who are to be formed. That is something most educators would agree with, but it is not always easy to describe what that means in the process of becoming a healthcare professional. It is at this point we think the notion of subjectification could enrich the conversation within health professions education when discussing questions like what it means to become a (good) doctor. Not only does subjectification provoke other questions than PIF, but it also introduces to the discussion elements, e.g., how to deal with

[8] "The first thing that the experience of resistance teaches us is that the world we live and act in – and this includes both the material world and the social world – is not a projection of our mind but has an existence of its own. This means that it is fundamentally *other*" (Biesta 2012b, 94–95).

[9] For a different take on this topic, we refer readers to Vlieghe and Zamojski who would say that such an aim would qualify more likely as an ethical aim and not so much as an educational one (Vlieghe and Zamojski 2019, 73).

responsibility, that could benefit positively from more explicit attention in medical school.[10]

Making implicit ontological assumptions of educational theory and practice explicit, and approaching students as subjects with their own freedom, agency, and responsibility are two arguments that show the difference between PIF as a *psychological* and subjectification as a *philosophical* concept.

3.4.2 PIF as Socialisation Versus Subjectification as Different from Socialisation

Professional Identity Formation is, rightly so, often considered as part of socialisation. Brown and Finn (2021) in their discussion of the concept state that:

> To advance knowledge in regard to mechanisms of social reproduction within health professions education, scholars must carefully consider what they mean when they say 'socialisation'. (781)

In discussing the three domains of purpose, Biesta (2020b) specifically conceptualizes socialisation as:

> The (re)presentation of cultures, traditions, and practices, either explicitly but often also implicitly, as the research on the hidden curriculum[11] has shown. (92)

The work of identity takes place within this domain because it is aimed at reproducing specific identities:

> …the "work" of identity actually takes place in the domain of socialisation. It is, after all, in that domain that education seeks to provide students with access to traditions and practices, with the invitation to "locate" oneself in some way in such traditions and practices (bearing in mind that this is not a process over which we have total control, also because our self-identifications may be quite different from how others identify us). (Ibid., 99)

What Biesta proposes here is that socialisation is a question of becoming part of an *already existing order*. This is a legitimate and useful task of education. Education always implies the question of what 'we' want to conserve and transmit to new generations. Society legitimately demands education socialises students. For health professions education, this question often comes in the form of professionalism discourse (see, for example, Cruess et al. 2014).

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[10] For more on the connection between identity and responsibility in medical education, see Yardley et al. (2020).

[11] The hidden curriculum in medicine was first described by Hafferty and Franks in 1994 as "the values, attitudes, beliefs, and related behaviors deemed important within medicine" and that are internalized "not within the formal curriculum but via a more latent, one, a "hidden curriculum," with the latter being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques" (864–5). Here, Hafferty and Franks closely link the hidden curriculum to socialisation processes.

Whereas socialisation is aimed at the (re)production of a certain social order through the creation of identities, subjectification cannot be reduced to a certain order and, in a sense, disturbs it, or adds something new to it. Subjectification functions in a different realm than socialisation.

Building on Jacques Rancière's ground-breaking theory of emancipation, Biesta (2014) states that:

> Subjectification is about the appearance – the 'coming into presence', as I have called it elsewhere (Biesta 2006) – of a way of being that had no place and no part in the existing order of things. Subjectification is therefore a supplement to the existing order because it adds something to this order…. (47)

An overfocus on socialisation—or paying too little attention to the question how doctors-to-be may alter their professional order—may lead to a reduction of the possibilities of students to emancipate and develop their own ways of *being* within the profession. A critique may, thus, be that PIF works (implicitly) from a perspective which does not make (enough) space for the recognition of the potentiality of medical students.

3.4.3 PIF's Third Person Perspective Versus Subjectification's First-Person Perspective

The last core difference between PIF and subjectification, or the related difference between identity and subjectness, is that identity is linked to a *third person perspective*, whereas subjectification approaches education from a *first-person perspective*. Whereas identity concerns the abstract question of *who* I am, subjectification emphasizes the question specific *how* I am.

Research on PIF builds on literature in developmental psychology (Cruess et al. 2015). This psychological point of departure means that the focus of personal growth in the context of becoming a doctor is mostly understood as an individual pursuit to become part of a pre-existing profession (i.e., identity within that profession)—albeit the social nature of a person's identity construction is increasingly acknowledged in identity research within the health professions (e.g. Monrouxe 2010; Monrouxe and Poole 2013; Monrouxe and Rees 2015). The question here is *who* you are as a person and professional—a question of identity. From an educational point of view (Biesta 2014), identity formation, be it professional or otherwise, ultimately is about the question of *how* you are as a person and what you can do with your identity:

> [I]t seems safe to say that identity concerns the question of who I am, both in terms of what I identify with and how I can be identified by others and by myself. The question of subjectness, however, is not the question of who I am but the question of how I am, that is to say, the question of how I exist, how I try to lead my life, how I try respond to and engage with what I encounter in my life. It therefore includes the question regarding what I will "do" with my identity – and with everything I have learned, my capacities and competences, but also my blind spots, my inabilities, and incompetence – in any given situation, particularly

> those situations in which I am called upon or, to put it differently, in which my "I" is called upon. (Biesta 2020b, 99)

From the third person perspective that identity entails, we can describe ourselves as being so and so, doing this and this, and working in that and that function. In doing so, we identify with others or groups of others. Education, in this line of thinking:

> Is seen in terms of the creation of particular identities – the lifelong learner, the good citizen, the high-achieving student – and in terms of the creation of a competitive, stable, and successful social order. (Biesta 2006, 99)

This perspective acknowledges the social nature of identity formation but leaves out what we consider a key issue in describing what it means to 'be in the world'. An issue that the idea of subjectness, indeed, does address.

Subjectness, in contrast to PIF, entails a first-person perspective and has to do with the idea of irreplaceability. In linguistics, the subject is literally the one doing the action, not the one or the thing *to* which things are done. In the context of the formation of medical students, subjectness is about being an agentive subject, who can take initiative and exists in the world (see Chapter 11 for an interesting view on agency in health professions education). Subjectness is about how I exist, that is, *what I can do with my identity* in the world around me.

For medical students the question of what they can do with their identity as a doctor is a very relevant one. For medical educators it may show how subjectification somehow changes the way in which they look at the development of students: having a vision, embedded in a curriculum, on how medical student form their professional identity may fall short from what we consider as an educational task: teaching students how to exist in the world by dealing with their freedom and its limitations. The difference between a third- and first-person perspective thus is highly relevant when thinking about 'formation': it constitutes the difference between treating students as objects which are to be formed, versus subjects with agency and freedom to choose.

3.5 Conclusion

We started out by claiming that Professional Identity Formation is a conceptual area within health professions education where 'learnification' as a development becomes visible. Starting from the three domains of educational purpose suggested by Biesta, we suggest that PIF is foremostly a domain of socialisation, exemplified in an overfocus on individual learning goals, competences, and pre-moulded trajectories of development. Thinking about education in an *educational* manner, identity may not be the *only* concept we should concern ourselves with regarding the formation of students.[12] What it means to become a good doctor can not only be a question

[12] Our approach developed here differs from Vlieghe and Zamojsk's (2019), who state "*that educational equality is about sameness, but not in relation to any identity*"(p. 48). Interested readers are referred to their work for further discussion.

of identity. As subjects, we are subject to specific situations and we find ourselves 'thrown' into the world, existing and taking up our own existence in a way in which only we ourselves can do.

Thus, subjectification seems a promising concept for educators and educationalists to use as a springboard to embark on conversations concerning questions of freedom (lacking a certain pre-established malleability), responsibility, and activity. Subjectification helps us to understand what we really mean when we want to create room for individuals to express themselves as unique and increasingly established members of the medical profession (see Lave and Wenger 1991). A radical idea would be to suggest that we avoid the use of the idea of PIF altogether, since it constrains the formation of students too much to the domain of socialisation and may even facilitate an instrumental approach of treating students as objects rather than subjects. For now, we would suggest that health professions education look beyond the idea of identity towards the notion of subjectification, without disregarding identity as an apparently fruitful domain of research and practice.

Two critical notes need to be made about this chapters' discussion on PIF and subjectification, though. First, subjectification, though valuable as an addition to PIF, seems to instigate confusion sometimes: what exactly does it mean, how is it related to identity? Despite it being hard to grasp and even harder to put to practice (more on that below), the concept of subjectification may help health profession education to conserve its educational character.

A second critical note is that identity discourse may be more flexible than what is presented here. For example, we speculate that the notion of 'identity dissonance' could be fruitfully related to the idea of subjectification. Such links between identity and subjectness could move discussion in the field beyond a contrastive approach to PIF and subjectification towards a productive dialogue.

3.6 Implications for Practice

The conceptual differences between PIF and subjectification have consequences for health professions education research and for how we 'treat' students in health professions educational practice. We summarize these in Table 3.2 and discuss some in more detail in Sect. 3.6.1 and 3.6.2.

3.6.1 Implications for Health Professions Education Research

We would like to draw attention to two broad suggestions for health professions education researchers. First, health professions educators should be conscious of

Table 3.2 Practice points

1	Recognize the complexity of educational practice by paying attention to the connection between often implicit philosophical assumptions about existence and educational theory
2	Add subjectification as a specific concept to health professions education discourse to enrich discussion and practice
3	Approach students as subjects, emphasizing their freedom and uniqueness, not solely as objects
4	Do not treat subjectification as a learning outcome but create room for students to 'come into presence'
5	Teachers and students can develop a grownup manner through which they can engage with the idea of existing as a subject in the world, which entails dealing with the experience of resistance

often implicit educational theory in health professions education discourse—such as the implicit notion of the link between learning and teaching.

Second, we suggest that the three domains of educational purpose, and subjectification specifically, could bring about a new and more educational conversation in health professions education literature. Future research could attend to subjectification as a research object to further facilitate its place in the health professions educational curriculum.

3.6.2 Implications for Health Professions Education Practice

In terms of teaching, the chapter's discussion of PIF and subjectification leads to three suggestions. Firstly, educators must strive to challenge views that conceptualise students as objects. Students in higher education may sometimes be reduced to 'numbers' or 'objects', whereas our educational task and responsibility should be to make space for students to exist as subjects. This would mean that we view teaching not as something which is *done to* students, but as something which is *experienced by* students, individually and collectively. The relational aspect and the existential nature of the concept of subjectification are very valuable in this plight.

Secondly, educators must understand that students cannot be 'subjectified'. Starting out from the three domains of educational purpose, we could conceptually envision students becoming more qualified and socialised. Subjectification, however, presupposes initiative from the subject itself, and can therefore never be done *to* them. Hence, we would suggest educators refrain from oversimplified operationalisations of subjectification as a learning outcome.

Third, related to our discussion of the notion of resistance, it is important to realize that teachers and students not only *experience* and *react to* resistance, but that teachers and students can also *use* or to *coexist with* resistance to achieve what has been called a "grown-up" way of existing in the world (Biesta 2019).

In terms of curriculum design, we suggest that educators and institutions create room for 'coming into presence'. Subjectification cannot be done to students, but education can create room for it. To create room means to leave room within the limits of socialisation, refraining at times from recreating a specific social order (e.g., explicitly assigning teacher-related tasks to students to involve them in the process and avoid traditional hierarchical order, or creating open slots in the infrastructure of a training programme for issues that are topical to students at that point in time, or emphasizing the possibility of doctors-to-be to enrich the world of medicine with their unique contribution). It also means space to discuss questions of freedom, emancipation and existence—which may not be forefronted, or approached in the same manner, if education and student formation is viewed through the lens of PIF.

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Chapter 4
The Serious Healer: Developing an Ethic of Ambiguity Within Health Professions Education

Mario Veen and Megan E. L. Brown

4.1 Introduction

Though of relatively recent popularity within our field, philosophers have wrestled with ambiguity for millennia. With roots in the Latin word *ambiguus*, which can be taken to mean "doubtful" or "double meaning" (Pinkus 2013), the focus of philosophy has often been to escape doubt, to deduce the singular meaning of the cosmos, of life, and of people, to eliminate uncertainty from our interactions with the world.

Of late, ambiguity, or inexactness, has been acknowledged as inherent to practice as a healthcare professional (Luther and Crandall 2011). There may be ambiguity, for example, in diagnosis, or creating optimal management plans. Yet, interest in this topic and area of study succumbs to the notion that ambiguity should be reduced, tolerated only when avoidance is impossible. Developing an ethic of ambiguity within health professions education (HPE) that encourages trainees and educators to embrace the fundamental role of ambiguity in human existence is necessary to help learners succeed within the increasingly uncertain landscape of healthcare.

In this chapter, we consider the tensions between ambiguity and certainty that manifest within HPE and propose de Beauvoir's foundational text "The Ethics of Ambiguity" ([1947] 2018) as a guide in developing pedagogy which facilitates adaptable professional identity formation amongst trainees (see Chapter 3 for an overview of identity literature in the field and proposed alternative to the concept of professional identity).

M. Veen (✉)
Department of General Practice, Erasmus University Medical Center, Rotterdam, The Netherlands
e-mail: m.veen.1@erasmusmc.nl

M. E. L. Brown
Imperial College London, London, UK
e-mail: megan.brown@imperial.ac.uk

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4.2 Tensions Between Ambiguity and Certainty

Ambiguity is, rather ironically, itself an ambiguous term. It is, therefore, important to consider: what is ambiguity, and how do we relate to it? These two questions are interconnected. If ambiguity is an undesirable state where we do not yet have desirable clarity, then our relationship might be one of accepting when we cannot change ambiguous situations and seeking out clarity where it is possible to do so. However, if ambiguity is not 'not yet certainty' but, instead, a default condition of our existence, then we must come to terms with this fact of life. In this way, the very definition and conceptualisation of ambiguity we adopt within HPE influences the way we handle the concept within pedagogy and research.

We anticipate that, within HPE, there may be differences in the value and importance individuals place on the concepts of ambiguity and certainty. As the health professions and science are intimately related, those that prefer certainty may connect their relationship with ambiguity to a standing in, or preference for, the natural sciences. These leanings are often referred to as a basis for the claim that certainty is, and should be, the default. However, this is no longer the case (Prigogine and Stengers 1997). Quantum physics, for instance, operates on the basis that it is fundamentally impossible to have certainty, and works with probabilities: a quantum particle has an ambiguous position that is described as a field.

4.3 Ambiguity Within Health Professions Education

Though there is no consensus definition (Hancock and Mattick 2020), research within HPE has attempted to cast light on the experiences of practitioners in reference to ambiguity, sometimes with aim of minimising or eradicating ambiguity, and sometimes with aim of informing educational strategies that teach others how to handle the experience of ambiguity. A particularly popular concept within HPE literature is 'tolerance of ambiguity'. Tolerance of ambiguity has been associated with improved wellbeing amongst healthcare trainees and reduced risk of burnout (Hancock and Mattick 2020). The online Cambridge English Dictionary (2020) defines the noun 'tolerance' as 'the ability to deal with something unpleasant or annoying, or to continue existing despite bad or difficult conditions'. Words matter, and the use of the term 'tolerance' implies that, definitionally, ambiguity is an unpleasant experience that we should seek to avoid. Though some authors have attempted to redefine 'tolerance' to reflect a range of positive and negative psychological responses towards ambiguity (Hillen et al. 2017), the tacit message inherent to the use of this term remains suggestive of a desire to avoid ambiguity. Indeed, the body of research concerning ambiguity within HPE seems to continue to interpret ambiguity as a negative experience. Despite attempts to remove the negative connotations of the term 'tolerance', ambiguity is not conceptualised as a default condition of our existence, but as an absence of certainty, a distressing black hole within HPE.

Viewing ambiguity *only* through this lens—as an absence of certainty—stifles opportunities to progress thinking within HPE. If, instead, we conceptualise ambiguity as a default condition of existence, approaches to teaching and practice may be revolutionized in ways that could promote wellbeing beyond existing pedagogy.

4.4 Simone de Beauvoir and Ambiguity

Simone de Beauvoir is the veritable mother of ambiguity as a topic of contemporary discourse within academic circles, and her writing offers one such fresh view of ambiguity as a condition of existence, rather than an addition to it. An intellectual associated with the philosophical tradition of existentialism (the core tenant of which is that existence precedes essence), de Beauvoir philosophises at length about the nature of ambiguity and how to rationalise the concept in her foundational work 'The Ethics of Ambiguity' ([1947] 2018).

For de Beauvoir, ambiguity arises from a tension inherent to the human condition. Human beings are both subjects and objects simultaneously. A *subject* has agency and is free to decide and act in the world, whereas an *object* is at the mercy of other forces and has no will of its own. Just think of an operation: the surgeon is in control; they decide where to cut and how. But the patient in this scenario is just a body, an inanimate object that has no say in their operation.

As human beings, we have a material body that is made of the same stuff as rocks and plants and tables. A table will never be a rock, just like a 1.80-m-tall person will never be a 1.50-m-tall person. If we are genetically disposed to have blue eyes, or to have a high risk of a certain disease, we are at the mercy of these 'facticities'. At the same time, we can be *aware* of our height, of our medical condition, and continuously recreate ourselves through choices and actions. Whether I am courageous or not depends on what choices I make in high-risk situations, each time. If I have been lazy or cowardly in the past, I can transcend this now by acting in an ambitious or courageous manner.

In addition to the ambiguity of our human condition—of the tension between our bodies and minds—there is also an ambiguity between an individual's past (which has happened and is therefore a known, given thing) and the future they are about to freely create. Given that the future effects of our present choices cannot be known, we feel the ethical weight of every decision we make. This is a "felt ambiguity between antecedent limits (facticity) and future possibilities (transcendence)" (Schroeder 2005, 299).

Ambiguity also pertains to what human beings create. Advances in technology, often perceived as progressive and positive, have led to negative outcomes. De Beauvoir names the atomic bomb as one such example. As we see in Chapter 16, our current way of life which has given us so much prosperity and fostered significant advancements in healthcare, also now endangers the livability of our home planet. In medical decision-taking, health care professionals are acutely aware that a surgery can be a solution and a risk at the same time. All medication has some kind of

side effect, and, sometimes, the cure is worse than the disease. Ambiguity arises from the unknown effects of our decisions. Chapter 17 also describes our ambiguous relationship with technology. Bernard Stiegler (2013) calls this the pharmacological dimension of technology: the same technique can be a poison, or a potion depending on how you use it.

The ambiguity of decisions de Beauvoir calls our attention to also extends to decisions and actions concerning others: what I choose and create freely may impede the freedom of others. They can become tools in my plan, means to an end. Upholding and advancing the freedom of others is, as we will discuss later in this chapter, the basis of de Beauvoir's recommendation for an ethics of ambiguity—a way of living in an ambiguous world where each one of us create our own meaning through our choices and actions.

De Beauvoir calls on us to *embrace* the fundamental ambiguity of our existence that comes about through tensions in the human condition, tensions between the past and future, tensions regarding human creation, and tensions concerning the freedom of others. Without ambiguity, de Beauvoir argues, we would not have either freedom, or ethics. We only have ethics because we can make mistakes. Ethics—including medical ethics—are no instruction manual for what to do in each situation. On the contrary, ethics are necessary *because* there is an inherent ambiguity for which no instruction manual can provide a solution. Even the choice for which set of guidelines to use, and when to adhere to or deviate from them is a free choice.

Translating this call to education: there is only the possibility to learn if there is the possibility to fail. Failure—at a task, or failing to answer a teacher's question, for instance—is not an impediment to education, it is its very condition. In all these ways and more, ambiguity is foundational to education. Even the construction of certainty—as imbues the stereotype of the paternalistic all-knowing white coat-wearing doctor—is not a negation of ambiguity, but a response to it, namely, by treating the world as a collection of facts and certainties.

In the remainder of her book, de Beauvoir takes one's relationship to ambiguity as a starting point to describe different levels of maturity. The degree to which, and way in which, I relate to my human condition defines where I am in this typification. Once we have accepted that ambiguity is the human condition, and the default condition within HPE, then we can draw upon de Beauvoir's typification as a description of professional identity development.

4.4.1 The Game of Being Serious: The Serious Healer

Children generally grow up in a protected environment in which all ambiguity is shielded off to them by adults. Unaware of the financial, health, and ethical choices their parent had to make in the convenience store to choose the food they have on their plate, children are simply tasked with eating. Their parents are their idols, literally, in the sense of all-knowing, all-powerful gods. They are unaware of how they lie awake at night thinking about which choices to make. When children play with each other

and imitate a 'mother' or a 'doctor', de Beauvoir writes, they are actually *serious*. The role they play is that of the idol. The "game of being serious" (de Beauvoir [1947] 2018, 39) is to treat choices and values as *things*. Bedtime is just as real a *thing* as a table you can bump into. This is not just the case for children.

At one point in our lives, however, the illusion of living in an unambiguous world is shattered, and the world is revealed to be profoundly ambiguous. The transition to adulthood—not in the sense of age, but in the sense of having a mature relationship to ambiguity—depends on how people respond in those moments in which existential ambiguity is revealed. This can be the moment when a loved one dies, when an adult breaks out in tears, or even a moment where an adult hesitates. Most people, at least in the early stages of their identity development, respond to the condition of ambiguity by remaining *serious*. It means that they now *choose* one identity, but consequently treat this identity as a real *thing* instead of a *choice*. They start to *believe* that they are the identity they have created. In de Beauvoir's existentialist philosophy, at least, we never *are* an identity (an essence). We are *nothing* in essence and *always* becoming.

Within HPE literature, professional identity development is most commonly conceptualised as a fluid process—one's identity is not fixed but, rather, always forming, shifting, and changing (Monrouxe 2010). We see de Beauvoir's philosophy echoed here in that we are always becoming. At the beginning of healthcare training, students are highly motivated, but their sense of what it means to be a healthcare professional is often unrealistic and idealistic. The attending (or consultant) appears as an all-knowing physician, and the best one can do is to imitate them as closely as possible. However, there is always a moment in training where students realize that even the most senior members of the healthcare team are operating on the basis of an ambiguous world. There are no perfect choices. At these moments, students and trainees can either choose to embrace ambiguity, or to choose one identity or model for being a healthcare professional that they stick to as the way a doctor should act. For instance, is their 'move' to always refer to 'the evidence' as if the scientific literature will tell them what to do, ignoring science's inherent uncertainty and epistemological pluralism (Tonelli and Bluhm 2021)?

The "game of being serious" is not just played by children. As De Beauvoir ([1947] 2018) remarks, "all men have been children" (37). She writes that this game

> …can take on such an importance in the child's life that he himself actually becomes serious. We know such children who are caricatures of adults. (idem, 39)

Writing in the 1940s, De Beauvoir commented on women of her time who could be playful not *despite* their not being regarded fully adult (e.g., having the right to vote), but *because* of it: "they can exercise their freedom, but only within this universe which has been set up for them, without them (39)." It is easy to connect this to the context of medical education, and the debates about students being 'in the lead' and having to take ownership of their training. If we do not regard them as mature learners from the start, we might present certain guidelines and ways of dealing with ambiguous situations as set in stone. It also makes clear that "serious" does not primarily refer to our everyday use of the term, as a stern attitude, but to regarding values as things.

The crucial point here is that, if a person's response to ambiguity is to stick to one identity, they regard their identity as fixed. They may be highly talented and have chosen a way that very closely fits with how we want healthcare professionals to be and act in our society. Their fixed identity may work under given circumstances, but if circumstances change and require them to be or become something else, they run into difficulty. The serious healer has made their choice of what kind of doctor or nurse or physiotherapist to be at one discrete moment in time. In one instance they recognise ambiguity, in the sense that there are multiple possibilities for how to 'be' a member of their profession, and run from it, sticking to one way of being for the rest of their professional career.

But, de Beauvoir continues, there are other options. We need not all be serious healers in regard to our professional identities. There are chances for development beyond this stage, towards more mature identities, or ways of being.

4.4.2 The Nihilistic Healer

When approaching life as a serious healer fails, individuals may adopt a nihilistic way of being. Faced with circumstances requiring identity flexibility and adaptability but being unable to change in the way they need due to their choice of a fixed identity, a serious healer may become conscious of being unable to meet the demands of their profession, their patients, their colleagues, their students. Feeling unable to be anything, they may become a nihilistic healer, who actively chooses to be nothing. Deciding to give up any values in the face of a meaningless existence is an attempt to rid nihilistic healers of the anxiety of their free human condition. If they decide to be nothing, they deny the world, and they deny themselves. In contrast to children who, arguably, also deny the world, for nihilists, denial is a choice—they are aware of the world, of their freedom to choose, but run from this by retreating into nothingness.

There is a parallel between de Beauvoir's nihilist and the family of philosophical views known as relativism. Relativists argue that facts are relative to an individual person, or the context in which they are assessed. You may be familiar with a relativist yourself, when disagreeing with them they may return—'you have your opinion, I have mine, and they are all equally valid'. In relativism, you can choose to be who you want, to have the opinions you want regardless of the 'facts' of the matter. This is true only because relativists subscribe to a nihilistic view of the world, existence is all equally meaningless and pointless. Unlike the serious healer, who believes that there is only one model for being a healthcare professional, nihilistic healers focus on nothingness, the rejection of all values and fixed ways of being as a futile form of control. For students and trainees, it is of paramount importance to understand that, just because there is not one fixed identity of a healthcare professional, does not mean that practice is boundary-less and chaotic, that people can be whatever type of healthcare practitioner they want to be. Healthcare practice, importantly, must adhere to safety standards, if we don't treat people in certain ways or to certain guidelines, they will get sick and may even die. The nihilist is dangerous in a medical setting

because they refuse to engage meaningfully with ambiguity, to make necessary decisions. Though nihilists and relativists may think they are no longer taking a stand for anything, because everything is pointless, not taking a stand on anything, precisely *is* the stand nihilists and relativists take. Retreating into nihilism and refusing to make resolute decisions or take a stand for colleagues or patients is not only dangerous, but a decision in and of itself.

Within healthcare, nihilistic healers may also appear disillusioned, to reject the values of their profession or values they once held dear. They may possess little-to-no motivation to practice, or to work towards achieving a set of goals, even goals which are self-serving. Becoming a nihilistic healer is a negative response to the failed approach of 'serious healer'. It is not a stage we all travel through, or an approach to life we all experience in the same way. Support is paramount and recognising nihilistic views of the world as a possible response to difficulties in dealing with the ambiguity of existence should inform healthcare professional education and support.

4.4.3 The Adventurous Healer

Emerging from a nihilistic orientation, or directly in response to the failure of a "serious" approach to life, an individual may become an adventurous healer. Adventurers aim their efforts and lives at the pursuit of pleasure, and of glory. They do not deny their existence as nihilists do but acknowledge their desires and take delight in the pursuit of them. Adventurers are unattached to the end goal of their pursuits, enjoying action for its own sake, rather than for the pursuit of freedom for others. In the pursuit of their goals, they may treat other people as *objects*, as things, rather than as free and subjective beings.

Adventurous healers may view making a diagnosis within medicine as an expression of freedom and subjectivity. They may not see themselves as bound by "serious" values such as those responsibilities associated with long-term patient follow up, complex treatment, side effects of diagnosis and treatment, negative mental health sequelae because of their input. Making an accurate and complex diagnosis is a conquest to adventurous healers, they do not experience any particular attachment to, or connection with, the patients they meet, beyond their pursuit of this conquest. In this way, adventurers are indifferent to the content of their choice—they do not care who they treat, or for what reason, so long as the conquest exists.

They also wish to have their freedom, their conquest, recognised by others—they may seek self-promotion which acknowledges their skills, or to amass material wealth in recognition of their plight. In this way, patients are treated as objects by the adventurous healer, as 'things' through which adventurous healers express and realise their own freedom. Rather than being genuinely motivated by the needs of others, adventurers are primarily concerned with their own gratification and action for action's sake. Though adventurous healers embrace freedom to a greater degree than serious healers or nihilistic ones, this approach to life and healthcare practice is still a character of "bad faith" (Reynolds 2006, 150)—it is inauthentic—in that,

through embracing their own freedom, adventurous healers fail to recognise and uphold the freedom of others—in this case, of patients.

4.4.4 The Passionate Healer

In time, the adventurous healer's motivations may change, and they may attempt to make themselves complete through the pursuit of projects, rather than through more self-serving pursuits. With this change, they become the 'passionate healer'.

The passionate healer is the closest of the aforementioned ways of living towards accepting and upholding freedom, but similarly to the adventurous healer, the passionate healer treats other people as objects in the pursuit of their own, personal freedom. Passionate healers seek fulfillment by throwing themselves into their hobbies, relationships, and their jobs. Unlike the adventurer, the passionate healer is not indifferent to their patients, to the reasons why they are engaging with them, they are, instead, passionately attracted to them. In many ways, the passionate healer is similar to the serious healer. Like serious healers, passionate healers choose a value to live by and organise their life around their value. Within healthcare, this may be work with a particular patient population or demographic, with people with a certain disease or illness, or with patients receiving a particular sort of treatment. However, unlike the serious healer, who denies their freedom by adhering to a fixed identity, the passionate healer chooses this identity as an expression of personal freedom.

However, passionate healers still fail to treat others as subjective, free beings as they conceptualise patients as objects of their passion e.g., their passion for a certain treatment modality, disease management or social justice value. As de Beauvoir puts it:

> …the whole universe is perceived only as an ensemble of means or obstacles through which it is a matter of attaining the thing in which one has engaged his being. Not intending his freedom for men, the passionate man does not recognise them as freedoms either. He will not hesitate to treat them as things. (28)

One could suggest whether, if the value a passionate healer is devoted to is noble, such as the pursuit of social justice, or treatment of a rare and complex disease, whether it matters that they may treat individual people as objects. Yet, being driven by their passion makes passionate healers potentially dangerous in a medical setting. Like the adventurous healer, they may demand their passion is recognised and validated by others, seeking this validation at the expense of upholding patient freedom. Everything is ultimately subordinate to their passion, they are blinded by it, and in professions that demand the holistic care of patients, and a patient-centered approach to practice, this way of being is at odds with best practice.

4.4.5 The Genuinely Free Healer

The character we should all aspire towards, according to de Beauvoir, is that of the genuinely free human. Freedom is crucial to all ethical action. Without realising our personal freedom and upholding the freedom of others, it is impossible to live a moral existence. The genuinely free person, for de Beauvoir, is the only character who can promote the freedom of others. In healthcare roles, where significant power dynamics exist between practitioners and patients, actively promoting the freedom of patients is essential in the pursuit of patient-centered care that values the thoughts, opinions, experience, and lives of patients.

Realising freedom involves embracing the ambiguity of existence, rather than shying away from it, and acknowledging it as a foundational premise of our being. In doing so, we can make free choices in our day-to-day lives, and take responsibility for these choices, our attitudes, opinions, and values. This is the only way in which humans can justify their actions, if recognition and embracement of ambiguity and personal responsibility is at the heart of the moral choices we make. Freedom is not an absolute value—viewing it as such would risk turning one into a serious person who prizes a transcendent value and fixed identity above all else—rather, it is developed through our *relationships* with other people. Freedom is not even really a value as such, rather an end we should all aim to achieve in our interactions with others.

It is impossible to know the future, and so impossible to know whether the decisions we make will uphold the freedom of others. The important thing here is *intent*, recognising one's own freedom and the freedom of others requires the active pursuit of liberation, the desire of freedom for other people. For de Beauvoir, upholding the freedom of others involves social and political action to liberate the oppressed. Regarding health care, this may involve advocacy in regard to social determinants of health, national policy, or legislation. It involves recognition that the freedom of others is central to identity as an ethical health care practitioner, and that this requires social and political action.

4.5 Towards a Pedagogy of Ambiguity Within Health Professions Education

We can draw upon de Beauvoir's recommendations to offer insight as to how we can move towards facilitating a pedagogy of ambiguity within HPE. De Beauvoir ([1947] 2018) remarks that the "serious man" is the most widespread of all disingenuous attitudes towards ambiguity, because "every man was first a child" (37). We speculate that the same may be true of healthcare students and trainees—they are most likely to adopt the attitude of a 'serious healer' regarding the development of their professional

identity. As such, the following practice points are posed with the intention of shifting the dial amongst students and trainees, encouraging them to become genuinely free.

4.5.1 Start with Yourself

We recommend that those interested in moving towards a pedagogy of ambiguity within HPE first reflect on their own relationship with ambiguity, and attitude towards it. The more we recognise our own discomfort with ambiguity, or ways of coping with ambiguity that align with one of the disingenuous attitudes de Beauvoir outlines, the more readily we will be able to identify similar struggles amongst students and trainees. Possessing the ability to identify when a student may be struggling to cope with the ambiguity of medical practice is an essential first step in providing students with the support they need to move towards an attitude of genuine freedom regarding ambiguity. Further, de Beauvoir highlights that the genuinely free individual is the only person that can truly promote the freedom of others. Given this, in order to support the professional identity development of those one teaches and supports, educators and faculty must also embrace ambiguity themselves to become genuinely free. This is, perhaps, easier said than done—we do not expect educators or faculty who may currently possess a 'serious' attitude to become genuinely free overnight. Rather, we encourage all those invested in HPE to reflect on their attitudes, challenge them, and consider how they can aspire towards genuine freedom in the way that de Beauvoir illuminates.

4.5.2 Acknowledge Ambiguity

We have already mentioned the necessity of embracing ambiguity. Referring to earlier points in this chapter, we feel ambiguity is best conceptualised as the 'ground' of certainty. That is, ambiguity is fundamental to our experiences, and certainty depends on ambiguity as a preceding condition. In Chapter 5, the concept of 'acknowledgement' is proposed in reference to the practice of empathy. Applying this concept to ambiguity, it can be said that we all must acknowledge ambiguity to work towards a pedagogy of ambiguity within HPE. Acknowledgement is defined by Chapter 5 as 'any communicative behaviour that grants attention to others and thereby makes room for them in our lives'. We must grant attention to ambiguity as a fact of medicine. Acknowledging the condition of ambiguity within medical practice and HPE opens a relationship with the concept and helps us become familiar with ambiguity as a way of *being*, as opposed to something that is merely *experienced*, within our professional lives.

4.5.3 Start Early

Often within HPE, we try to protect or shield our students and learners from certain complexities, only opening complex doors at later stages of their training. De Beauvoir might say of this that, in protecting students from considering and acknowledging ambiguity, we treat them as children and shape them to be 'serious'—we have not offered them the chance within our pedagogy or curricula to develop in any other way. Exposing students to the practice of ambiguity and engaging in open, honest discussion about the ways in which we may acknowledge the ambiguity of medicine at an early stage of students' healthcare training and careers may go some way to encouraging students to move past a 'serious' attitude to ambiguity.

4.5.4 Connect Embracing Ambiguity and Ethical Action

For de Beauvoir, embracing ambiguity or, as we have proposed, *acknowledging* ambiguity, is the precedent to ethical action. That is, without developing one's relationship with ambiguity, it is impossible to act in a truly ethical way that supports and promotes the freedom of patients. We speculate that positioning ambiguity as central to the ethical practice of medicine may increase interest in discussion of the concept amongst institutional leaders, faculty, and students themselves. Many healthcare professionals are drawn to healthcare as a way to do some good in the world. Ambiguity is an important key in unlocking this potential, by way of ethical action.

4.5.5 Focus Action on the Needs and Freedom of Patients

The final practice point we would like to highlight concerns focusing on the needs and freedom of patients within education and educational spaces, rather than on upholding abstract values. As we have previously discussed, freedom is not an absolute value, it is developed through our relationships with other people, and is an end to aspire towards within interactions. As educators, we must all reflect on the ways in which we actively pursue the liberation of patients, and any abstract values or ideals that may be preventing us from upholding freedom for others. The concept of professionalism, for an example, may be treated by a 'serious healer' as an abstract value that is prized and pursued above all else—their professional identity is fixed to this concept. Yet, it is increasingly recognised that organisational definitions of professionalism are often restrictive, iniquitous, and may prevent engagement with advocacy for patients (Brown et al. 2020).

Table 4.1 Practice points

1	Start with yourself and lead by example by reflecting on your own relationship with ambiguity and certainty
2	Acknowledge ambiguity as a fact of medicine
3	Start early with students and trainees in regard to the acknowledgement of ambiguity
4	Promote embracing or acknowledging ambiguity as a precedent to ethical action within medicine
5	Focus action on the needs and freedom of patients, rather than on upholding abstract values

Action in this context, for de Beauvoir, involves social and political action to liberate the oppressed. Within HPE, this may involve engaging with, and encouraging student engagement with, healthcare advocacy and the challenging of the social inequities at the root of healthcare inequality. Upholding a concept like professionalism as an abstract value above the needs and freedom of patients in this context contributes to the oppression of patients and is a character of bad faith regarding ambiguity. As such, this practice point recommends that, at the core of students', trainees' and practitioners' professional identities must be a focus on the needs and freedom of patients. Chapter 9 considers concrete ways in which a desire for social justice may be practically enacted within HPE and so is also of relevance here.

The practice points outlined in the above sections are summarised for clarity in Table 4.1.

4.6 Conclusion

In this chapter, we set out to consider the tensions between ambiguity and certainty that manifest within HPE, and the ways in which de Beauvoir's comprehensive text 'The Ethics of Ambiguity' can act as an authority in developing a pedagogy of ambiguity within HPE. We propose that such a pedagogy would act as a robust facilitator of professional identity within higher education, encouraging students to *acknowledge* ambiguity at a formative stage of their education, supporting them as they come to terms with the fact of ambiguity within medicine, and promoting ethical action through a focus on the liberation, or freedom, of patients.

Ambiguity is not something we must merely learn to tolerate within HPE—rather, it is foundational to our very professional development. Reframing pedagogy in a way which recognises that ambiguity is the ground to certainty will move HPE and research closer to a central aim of HPE. That is, closer to graduating professionals who respect and uphold the freedom of others, above all else.

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Chapter 5
Acknowledgement: The Antidote to Skillification (of Empathy) in Health Professions Education

Anne de la Croix, Grace Peters, and William F. Laughey

5.1 Introduction: Empathy and Education

> You want to study medicine. Ever since you were very young, you have wanted to help people. When you were 10, your next-door neighbour ended up in a wheelchair after a serious car accident. You loved your neighbour and often went over for a chat, and to see if you could help her. She always used to say that her doctors could learn a lot from you. You don't think you actually did anything. But the conversations with your neighbour started your fascination with illness and health. Since then, you haven't been able to imagine a more meaningful career than to work with people who are ill. You want to help them, to be there for them and their loved ones. You hope to get into medical school.

The challenge with a concept as complex as empathy is agreeing on a common definition. Without this, educators and researchers find themselves teaching and researching a variety of concepts, any of which may bear the label of 'empathy.' This, indeed, is the position in which we find ourselves: there is no one accepted definition of clinical empathy (Mercer and Reynolds 2002). There is a level of agreement that empathy is composed of cognitive, affective, action, and moral components, though researchers disagree as to the relative importance of these (Morse et al. 1992) and most attention is given to cognitive and affective components. For example, the Jefferson Scale of Empathy (JSE), emphasises the cognitive aspects of empathy,

A. de la Croix (✉)
Research in Education, Faculty of Medicine, Amsterdam UMC, location Vrije Universiteit Amsterdam, Amsterdam, The Netherlands
e-mail: a.delacroix@amsterdamumc.nl

G. Peters
Veterinary Communication for Professional Excellence, Colorado State University, Fort Collins, CO, USA
e-mail: Grace.peters@colostate.edu

W. F. Laughey
Hull York Medical School, University of York, York, UK
e-mail: william.laughey@hyms.ac.uk

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arguing that affective involvement is in the realms of sympathy, rather than empathy (Hojat et al. 2002). Halpern (2003), on the other hand, describes how feelings are central to our understanding of empathy, and that true empathy depends on a degree of emotional resonance with the other.

Of course, in HPE, 'the other' generally refers to the patient, though empathy for colleagues and students is also important. It is reasonable to consider whether empathy in the patient context is different from any other kind of empathy. In principle, we don't believe it is, but there are specific considerations. The concept of empathy includes the concept of opacity—the idea that whilst you may share the thoughts and feelings of another, you still retain your sense of self and don't become the other (Bizzari et al. 2019). This sense of self in a clinical situation is also a sense of professional self. This may modulate empathic reactions: for example, empathy for a relative may provoke tears, whilst empathy for a patient may, more often, be expressed in words of comfort for professional reasons. In addition, clinical empathy is driven by an ethos of care, and outcomes are more likely to carry health benefits, including the provision of emotional support, the desire to help problem-solve and the intention to prescribe or intervene in other therapeutic ways.

Whatever analogies or personal definitions we use for empathy, there is general agreement that empathy is connected to attentive listening. The psychologist Carl Rogers (1986) argued that for therapists to have empathy for clients they needed to actively listen and feedback thoughts and feelings. This link between listening and empathy has also been implicit within research with Simulated Patients (SPs) (Laughey et al. 2018). Indeed, whenever SPs talked about listening, they also talked about empathy, and vice-versa. SPs also detailed the types of attributes that allow patients to know that listening is taking place—attributes like eye contact; nodding; the mirroring of body language; asking the types of questions that indicate the clinician is hearing cues and picking up on them; summarising back to the patient to check understanding; and asking the kinds of open questions which help patients tell their story. Active listening combined with an interest in the whole illness picture, where clinicians explore not just the patient's symptoms, but how they affect the patient's life, and consider the patient's perspective—including the classic triad of ideas, concerns and expectations (ICE)—are at the heart of empathic, patient-centred approaches to communication (Kurtz et al. 2017).

In a philosophical inquiry into the nature of empathy, Davis (1990) argues that empathy is akin to a process of 'crossing over' in which a person suddenly finds they are closely aligned to another, a crossing that simply happens when the conditions are right and that cannot be forced. In those moments of eye contact, attentive listening, and striving to understand the perspective of the other, there will be empathic opportunities when thoughts and feelings resonate. Davis likens it to falling in love, again something that cannot be forced.

An analogy that is often used to capture the essence of empathy is "the ability to put yourself in somebody else's shoes", or "the ability to put yourself in somebody else's story" (Laughey et al. 2018, 665). Whilst this a helpful metaphor, it does not capture the full scope of the concept. Empathy has efferent as well as afferent components (Morse et al. 1992). It is all very well for a clinician to experience empathy for a

patient, but unless they communicate this back, the patient may never know. A fuller analogy may therefore be, 'the ability to let somebody else *know* that you have put yourself in their story'. This is, perhaps, why SPs generally welcome the so-called 'empathetic statement' (Laughey et al. 2018). Empathic statements usually take the form of brief statements of empathy, such as, 'I'm sorry to hear that', or 'I imagine that must be difficult for you'. These are one of the ways doctors demonstrate to patients that empathy is being felt. However, SPs also urge caution—it is easy to detect when an empathic statement is being forced out, essentially delivered in such a way that it is clear it is not sincerely meant. This problem of fake empathy is a significant one, and contemporary approaches to medical education are unwittingly exacerbating it (Laughey et al. 2020b).

There is good evidence that students freely admit to faking empathic statements (Laughey et al. 2020a). In teaching, they are encouraged to make statements of empathy even at times when they are not feeling empathic; they also witness their supervisors and peers making similarly hollow statements. In assessment, they feel the surest way to 'tick the empathy box' is through the liberal application of empathic statements, which in the pressured setting of an Objective Structured Clinical Examination (OSCE) assessment are almost always forced, rather than natural. This is a situation that students feel uncomfortable with—the disconnect between the giving of empathy and the feeling of it. This problem has been termed 'empathic dissonance' and defined as "the mental discomfort experienced by the act of making expressions of empathy that are not sincerely felt" (Laughey et al. 2020a; 2020b, 428).

The difficulty with insincere statements of empathy is that they cut across other efforts to create the empathic moment. This casts doubt on any attempts by educators to encourage students to force empathic statements, including the advice of the four habits model (advocated by one of the USA's leading health care providers, Kaiser Permanente)—this model recommends clinicians make at least one empathetic statement per encounter (Frankel and Stein 1999). Whilst the spirit of this advice may be well meant, if it results in clinicians trying to force an empathetic moment, the delicate conditions that encourage empathic 'crossing over' may be undermined. Using models and 'grids' to force specific behaviour, however well intended, can lead to a process we call *skillification.*

5.2 Skillification

> You got into medical school. It is wonderful and you love it. It is also hard, hard work. The study load is incredible, and you need to work a job on the side to make enough money. The exposure to suffering, illness and disease can be confronting, and learning about the limits of health care is tough and can dampen your spirits. Your OSCEs are coming up, in which you need to demonstrate your competencies. You desperately need to pass the test, and start looking at the score list for the different stations in the OSCE. You start preparing, by practicing empathic expressions.

It is beautiful that the call to humanize medicine has been heard in medical education. A 'good doctor' has ample clinical knowledge and is skilled in doing a physical examination or a surgical procedure, but, in recent decades, there is agreement that there should be more: a doctor should be a pleasant person to interact with, for colleagues and patients alike. The 'human touch' of physicians has found its way into medical education in many shapes and forms, and the growing attention to empathy is one of them. Empathy is a beautiful concept and is one of many concepts that has been introduced to medical education to humanize medicine and stress the importance of connection. Other such concepts include patient-centredness, compassion, reflection, collaboration, and communication. Yet when complex concepts—characterized by their elusive nature—are applied in medical education, they are forced to take on a different form to survive in the field. Indeed, the science of medicine requires a positivist paradigm, where things can be known (see Chapter 10 for expansion on this). But when elusive concepts appear within positivism, the Tyranny of Metrics forces complexity into neat grids (Muller 2019). Empathy turns from a 'fuzzy' concept into a set of phrases to utter in an exam, something you can 'do', rather than experience or create.

We call the problem behind empathic dissonance and fake empathy '*skillification*.' We define skillification as the process of defining, delineating, and inevitably reducing features of human communication in order to measure their use and assess how students use them. A similar process has been described by Nimmon (2020) as 'technification'. It starts with creating clear definitions and continues with descriptions of what a particular concept 'looks like' in practice. These traits are then translated into an observation grid, an assessment matrix, or a checklist. Common communication skills,[1] for example, include tasks like open-ended questions, reflective listening, summaries, and empathic statements. The emphasis on observable behaviours as skills is concerning, as it may be teaching the natural empathy out of students and moving them to a forced and unconvincing representation of empathy. It is also concerning as communication becomes a very specific endeavour, dampening diverse ways of expression and disadvantaging non-native speakers (Atkins and Roberts 2018). Skillification translates aspects of connection into tickable boxes of visible behaviour, which, in the process, disregards diversity and humanity—it is a reductionist approach. This way of working is of key importance in other parts of health professions (protocols for patient safety, ways of working in operating theatres), yet does not work when applied to 'unmeasurables' such as communication, empathy, and reflection.

[1] Communication, however, is so much more—Prof. John Skelton at the University of Birmingham in the UK consistently rejected the word 'skills'. Rather, in his department, teaching was all about 'clinical communication'—part of the reason his team thrived was because that concept was left undefined. We argue that leaving the precise meaning of complex concepts such as 'empathy' undefined might prevent skillification. It will however present the field with a different set of issues,namely: how to deal with ambiguity and how to measure progress of the undefined? This might be tricky, but we feel it is preferred over the danger of the current skillification: cynicism towards empathy, and a bad reputation of such a meaningful concept.

Reflection is another rich and complex concept that has been reduced to a checklist of visible behaviours devoid of personality. In requiring students to reflect on an activity, often in written assessed reflections, "reflective zombies" arise because of the dominating urge to make concepts measurable (de la Croix and Veen 2018, 394). Students learn to move through the visible behavioural steps that they have learnt to mean 'being reflective,' possibly without actually reflecting in their own unique way. A consequence is that reflection is falling into disrepute for being a meaningless check-box exercise. This is ironic, since reflection was first introduced into medical education to add richness, depth, and value. The skillification of reflection is similar to what we described is happening with empathy: empathy is operationalised as a list of visible (often verbal) behaviours, allowing (or forcing?) students to 'perform' empathy without experiencing it or living it. Literature about 'gaming-the-system' (Rees and Knight 2007; Mak-van der Vossen et al. 2019; De Leng et al. 2019) is fascinating, as it shows that students know what they need to show to progress and succeed in a specific context. Gaming-the-system behaviour can be linked to the (sometimes seemingly invisible, yet dominant) epistemological stance in the field: if measurement criteria are clear, students will steer towards those criteria when being observed or assessed. We fear this hinders learning about oneself and about human connection, so called 'transformative learning' (Mezirow and Taylor 2009), in which personal differences need to be explored and affective learning plays a big role.

A driver for these unwanted side-effects (empathic dissonance, zombies, gaming-the-system, etc.) in medical education is the urge to assess and measure everything. This is a strong urge in any educational setting, but, perhaps, it is even stronger in medical education. This makes sense, as monitoring and measuring have clear merits: it gives us insight in health care needs and can help in controlling quality—both very important when it comes to preserving life and avoiding death. The epistemological hierarchy is strong in medicine, and it privileges positivist, seemingly 'objective' research. However, the influence of this positivist paradigm extends to domains where it, perhaps, should not meddle. The epistemological hierarchy maintains that only knowledge that can be objectively measured is worthwhile knowledge. And our complex concepts pertaining to humane medicine have had to conform to this orientation to gain legitimacy. But applying checklists and measuring tools to empathy and reflection, for example, can have negative effects on the way medical students' humanity is allowed to develop, as everything has to be demonstrated, everything has to be 'countable'. The urge to measure complex concepts (i.e., empathy, reflection, professionalism, communication, collaboration, etc.) according to well-defined gold standards that often take the shape of rubrics, checklists, or questionnaires, might lead to superficial learning and the eventual dismissal of complex concepts.

It is an ongoing dilemma in education –how to teach and assess 'the human touch' without creating zombies, without stimulating gaming-the-system behaviour, and most of all, without limiting the diversity of viewpoints and personalities in the classroom, and the authenticity of future doctors. Students strongly associate empathy with virtue, something that makes you a better person and a reason why you came to medical school (Laughey et al. 2021). Without a certain *ethos*, students are not prepared or willing to undertake the time, mental, and emotional labour into

developing connections with patients. Students need to be prepared to make a habit of adopting that listening agenda and deploying those attributes of hearing the patient—it's not just having the skills to do them, it's having the ethos, the drive, the "ought." Skills alone are not enough, yet, somehow, they have become the focus. Scholars have attempted to overcome skillification by conceptualising empathy as a position or a stance, but, ultimately, empathy in medical education is deeply entrenched in a discourse of skillification that essentializes communication rather than envisions it as a life-constituting activity.

If we can reset, and move away from skills and towards attributes, we may firm up the belief in the value of empathy, or, at least, stop driving this cynicism towards it. The reductionist, technicist approach causes more harm than good when it comes to teaching empathy (and reflection, communication, etc.). We argue that digging around in philosophy and embracing philosophical complexity is necessary. One philosophical notion in particular, namely *acknowledgement*, feels like the right antidote to skillification.

5.3 Acknowledgement

> You made it. You are a doctor. And sometimes you actually get to do what you wanted: help people and be there for them. Every day, you get to use a snippet of knowledge, a little trick, or a spark of insight from your training. And every day you learn more. One day, you meet a lady who ended up in a wheelchair after a serious car accident. She reminds you of your neighbour. You are not able to cure her or help her in her new life with a disability. These are the limits of medicine. Instead, you sit and talk to her while she waits to be picked up. You listen to her story without saying anything. She feels your concern and care. She thanks you. You don't think you actually did anything. But you are making things better. Through connection. By acknowledging.

We propose the notion of acknowledgement as an antidote to the skillification of empathy in medical education. Importantly, we are not suggesting acknowledgement replaces empathy to become the new "pièce de resistance," as we fear this leads to an inevitable breakdown whereby medical educators then distil and assess "acknowledgement." Historically, acknowledgement goes by many names and finds itself among many traditions—Bateson's (1972) notion of validation, and Buber's (1988) description of confirmation, to name a few. Yet, we present a *philosophical* portrait of acknowledgement, inspired by Michael Hyde's ontological theorization and clarification, to generate a conversation about how we conceptualize and teach human connection in health professions education.

Michael J. Hyde in his book *The Life-Giving Gift of Acknowledgment* (2006) defines acknowledgement as "any communicative behaviour that grants attention to others and thereby makes room for them in our lives" (1). Indeed, acknowledgement is an observable behaviour, but it is the *ontological nature* of that behaviour that

distinguishes it from becoming a check-box exercise. Acknowledgement is a moral and ethical act rooted in the metaphysics[2] of relationality.

The need for every human being to be acknowledged is fundamental to relationality, as Levinas (1969) states, "the social relation… is the ultimate event" (221; emphasis added). Hyde takes up Levinas' claim in stating that it is the

> …ontological structure of existence that *makes possible acknowledgement*…the originating force for the human propensity to wonder about 'who we really are' and 'where we really come from'. (10)

Acknowledgement is an act that was first done for us—whether explained through the Big Bang, the Creation narrative, or any other generative myth (as Hyde unpacks)—some opening brought about existence *and* the ability to question it.

The fact that we question our existence makes it possible for us to acknowledge and cultivate the existence of others. Hyde develops acknowledgement through Heidegger's notion of being (*da-sein*):

> …that place, "there" ("da"), where being ("sein") can show itself to a consciousness that can not only feel, see, and hear its presence in the materials of everyday life, but can also reflect on and articulate understanding of the perceived event. (39)

In other words, it is our self-reflexive capacities to question existence that are embedded with the foundations of acknowledgement. In discussing being, Heidegger (1962 [1927]) claims that the human is, "distinguished by the fact that, in its very being, that being is an issue for it" (32; as quoted by Hyde 2001, 38). But our own existential concerns are not enough as when we reflect on our being, we find that it is interwoven with the existence of Others. We are only able to question our existence through the acknowledgement of others—without which, where might we find the language to even think (Jaynes 2000)?

Therefore, we ought to carry on the dialogic process of acknowledgement that was first afforded to us, as, without it, social death is inevitable. Hyde illustrates the importance of acknowledgement by asking, "what would life be like if no one acknowledged your existence?" The isolation, loneliness, anxiety, suffering, and loss of such an existence demonstrates what Hyde calls "social death." Social death occurs through repeated communicative refrains (i.e., avoiding a smile, moving past someone, dismissing a plea, etc.) and institutionalized forms of discrimination (i.e., racism, sexism, ageism, etc.). We are all in need of acknowledgement; it is a recursive process that frees humanity from the despair of social death through attentive communicative action. We offer acknowledgement to others as a life-giving act. This goes beyond mere recognition, or noticing, to a sustained openness towards others, "even if, at times, things become boring or troublesome" (Hyde 2006, 4). Most importantly, acknowledgement steers through the questions of empathic resonance and invites us to cultivate a space for being together through sustained openness, attention, and communicative action.

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[2] *The Oxford Dictionary of Philosophy*, 2nd edition, defines metaphysics as 'the branch of philosophy that deals with the first principles of things, including abstract concepts such as being, knowing, identity, time, and space' (Blackburn 2005).

As we move through the world, we come face to face with others who issue calls for response (that no one else can respond to in that particular moment). Hyde poses a question-and-answer sequence—"Where art thou?"/"Here I am"—to show the impact of our responsiveness in the continuous unfolding of acknowledgement in our existential existence. In coming face to face with others, there is the possibility of response, which is "the essential human deed" (Stambaugh 1992). Barad (2003) turns to the phrase "response-ability", as in the ability to respond and a moral obligation to do so. Acknowledgement is that essential communicative act whereby we grant attention to others and make room for them in our lives. Hyde emphasizes the verbal and non-verbal dimensions of acknowledgement, but, like Barad (2003) (see Chapter 12 for more detail on Barad's ontological approach), adds that communicative acknowledgement, "needs what it brings into being for the sake of ourselves and others: a space, a place, the planet's crust at the very least" (18) extending beyond human activity to the post-human affective entanglements of intra-activity (using Barad's vocabulary; see also Iedema 2011). Acknowledgement is a cultivating activity that creates space for others—physically and metaphysically.

Existential disturbances demand we question the nature of being, which are inherent to clinical practice. When coming face to face with life-changing illnesses or accidents, how we understand and make sense of world shifts. As Hyde (2006) eloquently states,

> …the face of a dying person speaks to us a fact of life that most people would rather forget. In avoiding their presence, we deny them the respect of acknowledgement and thereby run the risk of contributing to their pain and suffering of their social death. (185)

In moments of existential instability, the "call of conscience" rings out—"where art thou?" To answer this call of conscience ("here I am") we acknowledge, we show up, and stay open. Interestingly, this is not unlike the moral approach to empathy described by Halpern (2001), who uses the term 'compassionate curiosity': a drive to remain engaged with patients and stay curious about their situation. It is not a cognitive, affective, or epistemological process (like "stepping in another's shoes"), but an ontological one.

Indeed, we can envision resistance to this sustained openness to others and the practitioners' need for acknowledgement. We colloquially hear practitioners say, "if I connect with everyone, I'll burnout," or, "I can't be dependent on my supervising clinician or my patient to acknowledge me, because I'll be dissatisfied." Acknowledgement is not a one-to-one activity, but a:

> …caress of a 'suffocating embrace' that is always challenging us to overcome its inherent pain and suffering by way of action– the very thing whose constant performance [acknowledgement] sooner or later incites fatigue and weariness and thereby leads us back to the suffocating embrace…human beings can take control of themselves, and even in the face of horrifying circumstances display courage and responsibility. (Hyde 2006, 121–122)

The metaphysical conditions of acknowledgement push us to acknowledge others and pull us from others so we may sustain aside from their acknowledgement. Being in the waves of existence does not negate the necessity of acknowledgement to our existence—in the throws we act, even if we float for a moment.

The philosophical orientation of acknowledgement redirects us from questions of knowing (epistemology) to questions of being (ontology) (see Chapter 10 for full considerations of these terms). It is not about whether acknowledgement (i.e., empathy, patient-centred communication or whatever we want to call it) *authentically* occurs, or how we can *know* a medical student or physician accomplishes it. When we occupy ourselves with such questions—as the discourse of skillification requires—we become stuck in a black box of beetles (mental unknowables) that ultimately impinge how medical students might connect with patients. We can never know whether acknowledgement or empathy are authentically experienced (Wittgenstein 1963; Veen et al. 2020). In fact, Heidegger's ontological shift *presupposes inauthenticity* and invites self-reflection in the process of becoming (as being would have us to do) as a way through it. As Veen (2021) states, "the path to authenticity is to reflect on the ways in which I am always already in some way inauthentic" (144). For human connection in medical practice, it is questioning, 'How am I connecting or not really or even faking it? Why? What is that doing? What else is there?'

As human beings, we are often calling into question our own existence, or witnessing disruption in the lives of others (Hyde 2018). Attuning our consciousness to the calls from others ("where art thou") and acknowledging the humanity before us ("here I am") to genuine depths of care is profound. The *ethos* of acknowledgement fosters the abilities for us to know together through shared space and attention, as well as provides the opportunity for us to self-reflect on that relationality. Acknowledgement creates a dialogic space for us to dwell together and deliberate, which foregrounds collaborative agency and humanizes the Other before us. As clinical educators, we envision this deeper existential meaning as one that philosophy offers medical education, if only to start the conversation about what we are doing *is doing*.

5.4 Conclusion

> You have been practicing medicine for 10 years now. After roughly 10 years of training and 10 years of practice, you start thinking about what has helped you the most in the way you communicate with patients. You remember one or two communication techniques from medical school. A few impressive consultations between a consultant and a patient, that you observed during your clinical rotations, have stuck with you. But the most important contribution to being a 'good communicator' is harder to pinpoint. It is the movies you watched, the friends you made, the books you read, the way you relate to your family, the many different patients you met, the travels you made, the emotions you felt, the conversations you had. Communication is contact. And contact is acknowledgement. Of others – and of oneself.

In this chapter, we illustrated the challenge of empathy in medical education, how skillification works, and how it can turn a rich and meaningful concept into a superficial 'skill'. This worrying trend robs medical students of truly learning about humane health care and can make us all cynical about complex concepts in medical education as the meaning is 'skillified' out of them. We propose the concept of acknowledgement as an antidote to skillification.

Table 5.1 Practice points

1	Rethink and reconsider assessment practices
2	Talk about complex concepts and their meaning (and do not define them strictly)
3	Make use of patient participation in the curriculum
4	Invest in medical humanities
5	Create acknowledgement between teachers and learners

We are *not* trying to replace the concept of empathy with the concept of acknowledgement. Rather, by allowing acknowledgement to inform the underlying philosophy of connection, we can combat skillification and revitalise concepts like empathy, connection, and communication. We envisage medical education to rest on a healthy underground of acknowledgement.

This is all well and good to philosophize about, but health professions educators are people of action. So, what can we *do* to move toward a learning culture that is antithetical to skillification? We believe that there are five areas of key importance when designing curricula in which students are allowed to let their humanity grow and develop. They are summarised in Table 5.1 and elaborated on below.

First, as assessment and measurement lie at the heart of skillification problems, it is worth having a closer look at what needs to be assessed and *why*. The natural tendency in education is to start with learning outcomes and ways to check if these are obtained. An assessment and quality control plan might be high on the list of actions to undertake when designing curricula. However, for more intangible aspects of development and growth, such as empathy, some free space in the curriculum might be more suitable. We would like to challenge educators to think about assessment-free areas in the curriculum, as well as develop arguments that justify them within a tyranny of metrics and positivism.

Second, we need to take a close look at the way in which "traveling concepts" (Bal 2009, 13) such as reflection, professionalism, empathy, communication, collaboration, leadership, are operationalised in the field of medical education. This requires philosophical and critical analysis of the field. We need to ask each other, and our students: what does patient-centredness mean to you? When did you experience empathy? When and how do you reflect? In the humanities, philosophy, and social sciences, talking about complex concepts is standard practice. It is a very different model to that of stating empathy can be defined as this and it sounds like that. Inviting a dialogue based on lived experience is a fertile ground for cultivating unique humanity.

Third, to stimulate connection and contact, students might benefit from taking the patient's perspective. Involving patients in both the pre-clinical and clinical part of medical school is advisory. Wonderful examples of patient participation in education are luckily not hard to find, for example: GP trainees joining patients as partners in medical consultations (Mol et al. 2019), medical students visiting the homes of families with a special needs child to learn about the life with disability (Anderson

et al. 2019). These meetings can help forge bonds between future health care professionals and patients, will stimulate acknowledgement and make it easier for students to understand the patient perspective.

Although conversations with patients can be fruitful, witnessing them in aesthetic form can be transformative. The poems, stories, plays, and art that has been created around medical practice offers a starting place for conversations about complexity. Art has the power of 'making strange' (Kumagai and Wear 2014) and allows for deep learning that stretches beyond the cognitive level. In the words of painter Georgia O'Keeffe: "I found I could say things with color and shapes that I couldn't say any other way - things I had no words for." Interpretation is inherent to art, as is how we interpret and make sense of ourselves in relation to it. Reflection on ourselves, on others, on relationships, requires changes in perspective, which the arts and humanities specialise in. Good art changes us, and perhaps in further integrating the medical humanities, we can begin to cultivate physicians who consider their own relations to the profession (Finn et al. 2021).

Finally, and perhaps most importantly, as health professions educators we should be the givers and receivers of the life-giving gift of acknowledgement. Acknowledgement as a space-creating activity can be used to create a clear space where students feel welcome as their whole selves, including their everyday concerns and contingencies. Perhaps in doing so, we reconsider how we are pushing such intense pressures (perhaps only because we've experienced this sort of brutal indoctrination ourselves). Hyde has much to say about education and acknowledgement function, so it is with his words we leave you this final consideration:

> …by giving others the right and appropriate attention, listening and remaining open to them, and thereby creating a dwelling place… to feel at home while they discuss matters of importance and learn to care for one another's ideas. Genuine acknowledgement requires nothing less than entertaining this process of engagement. (Hyde 2006, 182)

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Chapter 6
Tracing Philosophical Shifts in Health Professions Assessment

Walter Tavares, Jacob Pearce, and Kevin Eva

6.1 Introduction

Assessment of clinical competence continues to challenge the health professions, leading educators and researchers to seek new solutions to existing and newly identified problems. Broadening definitions of competence, increasing complexities of practice, cultural variations including socially constructed performance norms or expectations, the valuing and devaluing of some features of assessment (e.g., objectivity and subjectivity), newly identified limitations in the way assessment is enacted, and much more, provide ongoing stimuli for advancement and change. Other related shifts, including new programs of research (e.g., entrustment), the introduction of educational approaches or policy changes (e.g., competency-based education), or simply broadening ways of thinking about assessment problems and solutions (e.g., careful delineation of what is (or is not) accessible to observers) also keep the field searching for ways to improve practice and manage unintended consequences.

But what is driving these shifts in assessment theory and practice? Health professions education (and, indeed, education in general) has shifted in the underlying philosophical positions shaping practice over the past 50 years and the subdomain of educational assessment is no exception. The implications of this general

W. Tavares (✉)
The Wilson Centre for Health Professions Education, University Health Network, Toronto, ON, Canada
e-mail: walter.tavares@utoronto.ca

Temerty Faculty of Medicine, University of Toronto, Toronto, ON, Canada

J. Pearce
Australian Council for Educational Research, Camberwell, VIC, Australia
e-mail: jacob.pearce@acer.org

K. Eva
Centre for Health Education Scholarship, University of British Columbia, Vancouver, BC, Canada
e-mail: kevin.eva@ubc.ca

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philosophical evolution are far-reaching but are not always clear in terms of how thinking about assessment has evolved nor with respect to their implications. In this chapter, we offer examples that illustrate how shifts in perspective have influenced practices in this domain in an effort to make the various worldviews currently influencing the world of health professional assessment more transparent and, ultimately, to promote future advances.

Some advances in this realm have resulted from tweaks to strategy within a consistent worldview, but others have been revolutionary, clearly linked to (or representative of) different ways of thinking. In the latter camp, Schuwirth and van der Vleuten (2020) described three distinct phases, spread over the last five decades, during which emphasis has shifted from measurement, to judgement, to systems of assessment (Schuwirth and van der Vleuten 2020). In the first phase, the prominent focus was on deconstructing competence to its component parts, striving to avoid human judgment and promoting strategies aimed at achieving objectivity and reliability. A core assumption driving this perspective was that, to be fair, competence had to be quantified and objectively measured. This phase is characterized by psychometric approaches and positivist views as the search was for means of uncovering truth and eliminating the noise that occluded it. As limitations inherent in the measurement paradigm became understood, including increasing awareness of context specificity, limitations of objectivity, and broader notions of expertise, a second phase emerged in which the focus turned to "assessment as judgment." This phase witnessed a greater reliance on work-based assessments, more versatile uses of assessment (e.g., the use of narrative feedback) and the valuing of observer differences in human judgment (ten Cate and Regehr 2019; Hodges 2013). Psychometrics was still dominant, but positivist views became de-emphasized as post-positivist, and in some cases constructivist or interpretivist, views began to take hold. Notions of 'error' began to change, as variation was argued to offer richness and meaning to assessment data rather than simply being 'noise' that had to be eliminated. Most recently, medical educators have begun to conceive of "assessment as a system" with greater recognition of the complexity of education and context; this phase values judgement and highlights the "fuzzy boundaries" between acceptable and unacceptable assessment solutions because unintended consequences and wicked problems abound; further, it promotes the construction of meaningful holistic narratives over sets of individual assessment instruments. Programmatic assessment is dominant here, with notions of constructivism, interpretivism and pragmatism offering better representations of the ways of thinking that led to this state.

Transitions such as those described above reveal at least three implications that anyone seeking to understand assessment in health professional education should consider. First, as the philosophical positions influencing education in general have changed, it is only natural that they would influence perspectives on assessment, leading to new ways of understanding problems and deriving solutions in this domain. By philosophical positions we mean:

> …sets of recognized assumptions and commitments or intellectual frameworks that provide assessment scholars with lenses for examining assessment problems and solutions. (Tavares et al. 2020, 2)

These philosophical positions influence how we think about, define, and represent the construct of interest (e.g., what is competence), what strategies and methods provide the best means to assess that construct, and what counts as justification in support of any claims made through the assessment activities and data generated. More fundamentally, they influence how we think of assessment itself: is it sensible to draw meaning from one person judging another's empathy? Is the act of evaluation a social or cognitive endeavour? In formulating an assessment, are we accessing constructs that reflect the individual or formulating representations based on our own understanding?

Second, there are practical benefits to examining assessment through the lens of philosophical positions. For instance, as constructivist/interpretivist views take greater prominence, a greater emphasis has been placed on the use of language to address limitations associated with the formative use of numerical ratings (Hanson et al. 2013) requiring that different standards are brought to bear when determining the utility of assessment strategies. That is, challenges related to the usefulness, structure, or defensibility of any one assessment tool or process become highlighted and new solutions brought forward through insights shaped and guided by adopting different philosophical positions.

Third, while transitions in thought can illustrate tensions in assessment, it is possible for different philosophical positions to co-exist and, as a result, it is particularly important to clearly state the position from which one is arguing. Disagreements about how to proceed, legitimacy debates, the use of familiar and similar language while holding different meanings, and the mixing and matching of ideas while focusing purely on methodological activities in the absence of their philosophical underpinning all sum to create confusion and non-productive conflict when individuals' assumptions and commitments are not made transparent or not given sufficient attention (Tavares et al. 2020). These moments, however, also create valuable opportunities for generative conflict leading to marked advances in assessment practice (Pearce and Tavares 2021).

It is, thus, in moments of transition in assessment that the applied value of considering philosophical positions can most readily be observed, and insights generated. In this chapter, therefore, we draw on instances in which philosophy has been applied, sometimes implicitly, to spark transitions in assessment in health professions education. Doing so will demonstrate the importance of interrogating philosophical positions to more deeply understand how shifts in assessment configurations occur. While this literature continues to evolve, our intention is to reveal where and how shifts have occurred over time to illuminate what they mean for our community going forward. As such, we do not seek to prove any one philosophical position right or wrong; nor do we believe it to be fundamentally flawed that proponents of each or various positions continue to contribute to the field; instead, we describe philosophical shifts as a means to be generative and, hopefully, stimulate new arguments and ideas by offering focus regarding what matters to assessment experts and how bridges might be built between theory and practice. Meaning and understanding shapes design, interpretation, and determinations of quality. As such, we hope to use the analysis of several

specific transitions as a means for enabling readers to use philosophical positions as meaningful and helpful tools for assessment development and argumentation.

6.2 Overview

To explore the impact of philosophical positions in assessment we have selected five examples. First, we discuss the labelling of assessment as formative or summative along with reasons researchers have come to challenge that dichotomy. Second, we explore how increasing emphasis on formative activity (assessment for learning) has led to programmatic assessment; here we describe how its evolution has shifted over time and how its development as an approach has leveraged different philosophical positions. That evolution has placed greater emphasis on rater-based assessments and, hence, our third example focuses on the role of raters (assessors) in assessment processes, examining how different philosophical positions have influenced how assessors are prepared for their task, what their contributions mean, and how we might use raters to make decisions about competence. Common critiques of rater-based assessment have focused on reliability challenges, so example four explores assessment transitions from the position of metrics used to determine a tool's utility. Specifically, we explore how the movement from Classical Test Theory to Generalizability Theory should be conceived of as an evolution in thinking, not simply an expansion of the underlying mathematics. This example, in particular, outlines how one's philosophical position cannot necessarily be inferred from the tools they apply. Finally, we end with a look at the most fundamental of all concepts in the assessment world, validity, scoping its transition over time along with how different philosophical positions have been applied to that concept.

Each of these examples has been written as a vignette in its own right, independently illustrating a shift in the applied philosophy underlying assessment practices in the health professions. Taken as a whole, though, we argue that they illustrate that assessment's utility is not defined simply by the tools or methods one chooses to use, but by the interaction between those choices and the stakeholders by whom, on whom, and with whom they are engaged, thereby illustrating how fundamental philosophical perspectives are in this domain.

6.3 Example 1: The Formative Versus Summative Admonition

One need not look far to see how the move away from positivist views of education, with their assumption of an underlying reality, have begun to influence thinking about assessment practices. The first thing typically taught in any course on assessment is that it is critical to know the purpose to which assessments are being put (Yudkowsky

et al. 2019): if creating a summative record of achievement (assessment *of* learning) is our priority, then the reassurance offered by principles of objectivity, reliability and validity are easily perceived as paramount to ensure that trainees are being advanced or held back based on trustworthy and meaningful metrics; if, in contrast, assessments are offered primarily for formative purposes (assessment *for* learning), then lower standards in that regard are acceptable and greater attention should be paid to enabling professional development by questioning if the assessments are directing students to the right activities, stimulating motivation for further improvement, and enabling effective feedback to be provided.

Cynically, one can see this distinction as a means for maintaining assessment practices that don't hold up to psychometric scrutiny (by justifying them as 'for learning' rather than 'of learning') or as a means of rationalizing why assessment designers in 'summative' situations should not concern themselves with whether or not constructive feedback is provided. The problem with this dichotomy, however, derives from the notion that the tools themselves have no knowledge of the purpose to which they are put. That is, one can label an Objective Structured Clinical Examination (OSCE) as being purely for formative purposes, but what matters in terms of its impact is the implications the event holds from assessment candidates' perspectives (Pugh et al. 2018). If students perceive a threat to their academic progress, professional identity, or anything else, they are fully justified in treating any instance of assessment as a high-stakes moment, focusing on performing as well as they can and hiding their deficits rather than openly engaging in the discussions or behaviours that might best serve their learning (Mann et al. 2011). That is, they would be right in pursuing the behaviours that are most likely to offer reward in terms of 'maximizing their grade' rather than taking advantage of the developmental opportunity a "formative" assessment is meant to offer. At the same time, students do learn from summative exams, by virtue of preparatory activity, the retrieval-enhanced learning induced by taking the test, and any impetus the experience creates that leads candidates to look up answers to questions with which they may have struggled (Gielen et al. 2003). To ignore how we might optimize their capacity to do so by claiming 'that's not our purpose,' therefore, is to harm the quality of our education and healthcare systems by not taking advantage of some of the best data candidates could ever have to empirically guide their development (Eva et al. 2016).

The philosophical shift here is the recognition that assessment does not occur in a vacuum distinct from the beliefs of the people involved. Constructivism helps us to understand this given its emphasis on the social construction of reality. So, too, does hermeneutics and its teaching that the intent conveyed by a text (assessment in this instance) is filtered through the interpretation of others rather than acting on the world directly. Regardless of the explicit intent of the assessment designer, the impressions of the assessment takers (i.e., the recipients) and those at the institutional level using the assessment data matter and should not be ignored because they play a crucial role in determining the outcomes observed.

In fact, we would go so far as to say they play a critical role in determining the culture of medicine. Like most dichotomies, the black and white distinction between formative and summative assessment is a fallacy. If we continue to represent the

world in black and white terms, we should not be surprised when trainees then apply this type of thinking elsewhere, perhaps to perceive that medicine is simplistically about being right or wrong; that they treat uncertainty or mistakes, even in moments intended to be formative, as an indication that one is insufficiently skilled (Ilgen et al. 2019); nor should we be surprised that they appear reticent to disclose aspects of competence with which they are struggling (Mann et al. 2011).

One of the practical outcomes of this transition in thinking has been a reframing of the focus of assessments from formative vs summative to consideration of the stakes that are explicitly involved in any moment that might be deemed an assessment (Eva et al. 2016). That is, thinking about the extent to which a decision with repercussions will be made based on a particular event offers a better way of directing learner priorities, specifying the way data will be used rather than trying to convince learners that they should treat the activity as purely summative or purely formative in nature. Defining stakes on a continuum from high to low offers a way of moving away from black and white thinking to gradations, plausibly signalling a shift from discrete or reductionist tendencies in assessment to more nuanced and holistic appreciations.

This is important because saying "don't worry, this is only formative" can lack credibility or feel akin to an educational bait and switch both by virtue of learners mistrusting claims that the judgments formed will not influence their standing in the program and by virtue of having less confidence in the veracity of the data/feedback enabled; at the same time, to say "this assessment is purely summative" is to abdicate the responsibility of anyone seeking to improve healthcare through assessment (Eva et al. 2016). This movement from thinking of assessment as dependent upon stated purpose only, to treating it as equivalent to a diagnostic opportunity with emphasis on the way in which learners engage with it has forced extensive re-consideration of what we choose to do with information about trainee performance when it is generated, leading to promotion of programmatic assessment models that focus heavily on how assessments are approached by students.

6.4 Example 2: The Shifts to and in Programmatic Assessment

The programmatic approach to assessment in health professions education represented a major shift in thinking. Moving away from treating assessment purely as a measurement problem, the initial emergence of programmatic assessment as an idea treated assessment as an optimisation problem aimed at exploring how we might strike an ideal balance between the differing strengths and weaknesses of individual instruments to achieve the best overall outcomes (van der Vleuten 1996). The notion was built on an earlier utility model for assessment, which looked at striking the right compromise between potentially competing factors—validity, reliability, educational impact, acceptability, and cost. The fundamental value proposition advanced through the layering on of programmatic assessment, however, was the notion that optimizing

the assessment of competence requires treating the whole programme of various assessment tools and opportunities as greater than the sum of its parts.

At its core, advocates of programmatic assessment propose that there are potentially rich and meaningful data from assessment processes that can be useful for *both* progression decision-making purposes and educational purposes, but that the former should be put into play only after sufficient information has accumulated. As such, programmatic assessment models place great importance on how assessments are approached by students. One of its explicit aims, in fact, was to re-position assessment in the space of instructional design to emphasize the importance of high-quality feedback (van der Vleuten and Schuwirth 2005). To do this, programmatic assessment encourages the removal of pass/fail decisions from individual assessments. This facilitated the transition away from traditional formative/summative distinctions by thinking of stakes along a continuum, as outlined in the preceding section; no individual moment is high stakes, but the accumulation of evidence about learner progression can enable high stakes decisions. This necessitated a more longitudinal approach with decisions meant to occur at checkpoints rather than after each and every measurement. Expert committees were tasked with making the high-stakes decisions by drawing on assessment evidence accumulated from a range of lower-stakes assessment moments. In programmatic assessment, it is the diversity of methods and the triangulation of disparate forms of assessment data that build an evidence-base to inform decision-making (van der Vleuten et al. 2019; Dent et al. 2021).

Applying a philosophical lens to analyse this shift more thoroughly allows us to uncover concurrent implicit shifts *within* programmatic assessment (Pearce and Tavares 2021). For instance, in the initial conceptualization of programmatic assessment, reliability was cast as a sampling problem. Proponents of the approach noted that higher reliability metrics were achieved with increased testing time, which consequently led to suggestions to gather more data. This is illustrated in the often-cited pixel metaphor in which a poor resolution image of learner competence becomes clearer with more data points. Such a metaphor is grounded in psychometric or measurement-based thinking, assuming that a unitary conception of learner competence can somehow be captured as long as different methods are used over time.

As programmatic assessment evolved, however, a stronger emphasis on the role of assessment for learning emerged as a central tenet and learning became more embedded into assessment activities. This implies that assessment is not simply aimed at gaining a clear impression of a static image, but rather, that the measurements themselves alter and influence the image in ways that may prevent it from ever appearing as a uniform whole. In less metaphorical terms, this transition brought with it a deliberate blurring of the measurement vs learning boundaries explored in the preceding section, leading to greater acceptance now that learners should be mentored and coached while taking on more shared responsibility for their learning and assessment if the pedagogical opportunities assessments create are to be effectively dual purposed.

More recently, a range of qualitative research approaches have permeated the programmatic assessment discourse, moving hand in hand with the emergence of an

explicit constructivist/interpretivist framework (Ginsburg et al. 2015). Notions such as information richness, narrative feedback and meaningfulness of data now appear more often in the assessment discourse with the idea that learners need to be supported to build insight from assessment data to overcome blind spots created by their current conceptions (Eva et al. 2014). This move towards a constructivist ontology when it comes to competence, coupled with the emphasis on rich and meaningful evidence to ensure robust and credible committee decisions, is quite a radical departure from earlier conceptions of assessment in which it was simply assumed that truth would be recognizable and improvements actionable if good data were provided.

Today, programmatic assessment has become a consolidated sub-discipline in health professions assessment, and we have noticed a more explicit pragmatist approach to programmatic thinking as implementation attempts proliferate (Pearce and Tavares 2021). That is, some have aimed to incorporate aspects of programmatic assessment without necessarily subscribing to its entire framework. As programmatic assessment continues to evolve, many new questions and tensions arise. No longer is sampling considered a means to eliminate error of measurement and get at an underlying truth; rather, it has become better recognized that learners change with time, that competence development is neither unitary nor consistent, and that context matters, all of which sum together to suggest that there might be meaning in variability observed rather than that variability necessarily reflects weakness in assessment. Research in rater cognition has come to celebrate such diversity and idiosyncrasy of judgment rather than assuming that the fundamental purpose of sampling is to do away with the varied perspectives they bring to bear on the assessment of learner competence.

6.5 Example 3: The Shifted Role of Assessors in Assessment

Increasing awareness of the complexity and context-dependence of clinical practice has made assessment of competence reliant on assessor judgment. Any performance-based assessment of clinical competence, in fact, involves at least three components: the selection or generation of clinical stimuli (be they workplace-based or simulation-based); a learner interacting with that stimulus and displaying performance features (given that not all qualities are available for observation in any one performance; de la Croix and Veen 2018; Veen et al. 2020); and, an assessor who attends to, processes and translates performance features against a standard of some kind (Gauthier et al. 2016).

It is perhaps in this domain that the three broad transitions described in the introduction to this chapter best illustrate changing philosophical assumptions. In the era of "assessment as measurement", assessors were viewed as useful to the extent they could provide accurate and objective representations of the performance they observed, including whether or not they were effective at translating their observations onto the provided data collection instruments. Measurements of performance,

that is, were expected to be reported numerically with ways of confirming their accuracy occurring through consideration of reliability (i.e., the extent to which raters agreed with one another about how candidates should be differentiated) as defining the degree of error inherent in the process. Ways of improving rater performance included efforts to train them to be more accurate and more objective, to provide them with more comprehensive tools aimed at reducing bias, or to eliminate poorly functioning raters (Eva 2018). In other words, opinion was viewed as "error" needing to be eliminated if the data were to live up to the standards set by those holding positivist views. As challenges persisted and research continued, new ways of thinking emerged.

Over time, in fact, assessors became increasingly valued for their judgement; while recognized as fallible and subjective, the unique perspectives individual raters brought to bear became thought of as valuable indications of the variety of ways in which an assessment candidate would be viewed in the real world of practice (Gingerich et al. 2014a, b). Assessors, in other words, came to be recognized as bringing something to the assessment process precisely because of their diversity of perspective and their capacity to reflect the complexity of environments, interactions, and practices trainees could expect to encounter. Rather than bottlenecks in assessment activities, it is their unique backgrounds influencing their judgments as raters that enables them to produce more holistic representations of the multifaceted activities in which healthcare practitioners are expected to engage, not anything sufficiently reductionistic that could be perceived to be "objective".

This change in viewpoint led to many shifts in practice. For instance, researchers called for greater emphasis on rater judgement rather than striving to generate tools that would overcome or limit their capacity to use insight (Crossley et al. 2011). In valuing rater judgment, it also became clear that numerical ratings were limited and that other forms of data collection were necessary, particularly the use of narrative if raters' perspectives were to be made sufficiently clear to enable learners to understand and benefit from those perspectives. The philosophical assumptions in this "assessment as judgment" era of assessment, therefore, moved away from positivist ideals towards post-positivist assumptions (i.e., that measurement will always contain some degree of "error") and constructivist/interpretivist ways of thinking in which what was previously conceived of as "error" could now be considered to contain some degree of previously unrecognized "signal."

As a third, and slightly different, aspect of a philosophical shift related to the role of assessors in assessment, it is also worth noting that this view that assessor differences are informative, not regrettable, also included a transition from cognitive orientations to assessment as a social practice. Even simple efforts to judge learners' cognition, after all, are coloured by social factors that impact on what they are willing to reveal (i.e., the best we can observe is their expressions of their cognition), demanding recognition that assessment always takes place in a social context. In this regard, Gauthier's review illustrates that rater-based assessment was almost exclusively treated as a cognitive, information processing, activity with assessors' roles being to make observations followed by processing and integrating the information

collected (Gauthier et al. 2016). As new ways of thinking have emerged, the cognitivist approach became seen by many as necessary, but insufficient (Govaerts 2016). That is, the complex processes and interactions assessors have with trainees/learners came to be seen as a social process that enabled judgment rather than simply being a bias impacting upon it (Gingerich et al. 2011). Social influences, thereby, became thought to improve assessor contributions by reflecting the activities in which trainees were expected to engage during their clinical work and the competencies required to engage effectively in those activities. This corresponds with a shift in thinking about where competence exists—in the mind of the individuals, or in the dynamic interaction individuals have with team members, with considerable implications regarding what assessors are asked to attend to (Tavares et al. 2018). Combined with increasing use of narratives, the value of "subjective and collective" became a rallying cry for many in health professions education (Sebok-Syer et al. 2021; Hodges 2013). Interestingly, accepting the transitions described in this section demands expansion of the criteria we use to evaluate assessment strategies, but does not necessarily require a full-fledged abandonment of the tools that have been so strongly associated with the preceding positivist era.

6.6 Example 4: From Classical Test to Generalizability Theory

The foundation on which many of the criticisms of rater-based assessment outlined in the preceding example are based clearly highlight a particular worldview. When we get into the use of statistics to test the adequacy of our assessment protocols it is easy to conflate numerical with objective and, in turn, real. If competence is a trait that can be assigned to a particular trainee about a particular task, then the numbers that derive from our assessments should consistently reflect that competence regardless of who is offering the rating. Anything less than reliable measurement, the argument goes, suggests that the data collection strategy is flawed and untrustworthy as a statement about the candidate's ability.

What if performance is more a reflection, however, of a wide array of issues including patient characteristics, recent experience, psychological state, and other contextual factors that determine trainee competence rather than being independent of it? Further, what if performance is sufficiently multifaceted that assessors' variable backgrounds and the resulting variability in their perspective makes it such that even two rational and neutral assessors could reasonably come to starkly different conclusions about its quality (Gingerich et al. 2014a, b)? Content and context specificity have been recognized for decades and, quite intuitively, one would never dream of basing a judgment about someone's knowledge in a very broad domain like medicine on a few multiple-choice questions. Yet, we still express surprise when a single observation of communication skills is (or even a few are) imperfectly reliable. The problem with this disconnect between the complexity inherent in human behaviour

(including what may not be directly accessible to observers) and the expectation of replicable judgments, however, does not derive from our use of rating scales, numbers, or statistics; it derives from the way we think about them. Nowhere is this more evident than in the formulation of the statistics themselves.

Classical test theory, the traditional formulation of our reliability coefficients, was developed to enable mathematical determination of what portion of variance in the data emanating from an assessment can be attributed to "true" differences between candidates (in relation to the "error" contributed by other facets) (Yudkowsky et al. 2019). If the variance observed is largely driven by random noise or determined by anything other than candidates themselves, then the reliability coefficient will be low and one must worry about using the data to make claims about candidates. Cronbach's work on Generalizability Theory extended these models in an effort to enable the "error" variance to be parcelled out into more specific facets (e.g., does it derive from rater differences, from differences between cases, from differences in time, or from something else?) (Cronbach et al. 1972). Doing so allows better decisions to be made regarding how to improve upon an assessment's measurement properties. The true genius in his reformulation, however, has nothing to do with the mathematics (which are not all that different) and everything to do with the way in which he encouraged us to consider what the numbers tell us (which is unfortunately often overlooked).

In offering Generalizability theory to the world, Cronbach argued we should do away with the notion of measuring "true" variance. That is, despite continuing to use objective statistics in an effort to reflect the robustness of collected data, he recognized that what observations arose could only be generalized within the universe of observations collected. For example, if we measure what proportion of variance is attributable to candidates when they are evaluated by multiple raters at a particular point in time, those data tell us nothing about how well those scores will generalize to a different point in time or to a different set of cases. Internal consistency, inter-rater reliability, and test–retest reliability, therefore, are not simply different ways of measuring a tool's reliability; rather, they reflect fundamentally different tests of the extent to which data collected can be generalized across variables of item, rater, and time, respectively. As such, although we still try to determine the number of observations required to achieve a stable indication of one's strengths and weaknesses, transitioning from "true" variance to "subject variance" and from "error" variance to "residual variance" offers an explicit acknowledgement that our observations are constrained and determined by a variety of factors that are not always recognized (nor always observable).

This subtle but important difference in philosophy has marked implications as fundamental as whether or not it even makes sense to claim "the reliability of assessment instrument X is 0.yy". Too often we treat reliability as an entity in its own right when it is nothing more than a statistical calculation for which interpretation should be heavily dependent on implementation, context and philosophical position. Further, while under-recognized still, decades later, this shift from striving to measure objective "truth" without error towards striving to offer empirical evidence aimed at

building evidentiary and context-limited frameworks led to an even broader transition in our thinking about validity, championed by Kane (2013a), that suggests it to be a construction founded in argument rather than something that can be achieved full stop.

6.7 Example 5: Shifting Configurations in Validity

Validity remains *the* fundamental consideration in the development and evaluation of assessment; as such, it is perhaps not surprising that it has undergone several philosophical shifts over time that include evolving ways of defining and demonstrating validity evidence. Today, validity can be defined as the degree of theoretical and empirical evidence or confidence one has in the claims made based on data generated by an assessment process. In its simplest form, validity involves a clear statement about what is being claimed in assessment and consideration of whether those claims are warranted, given the available evidence. There is broad consensus that validity is best conceptualised as an argument-based model involving intended inferences or interpretations; however, this was not always the case, further illustrating that what claims to validity one can make are a matter of the philosophical position applied. Here we provide a brief history of validity, demonstrating shifts in the way we think about the concept in a manner that returns us to the notion of truth (the root of so many philosophical debates).

Earlier models of validity included an emphasis on three types: criterion, content, and construct validity (Kane 2013a). The first two, respectively, refer to comparing new assessment models against a plausible or 'true' criterion measure and emphasizing how a sample of questions or performances represents the construct of interest. While criterion validity usually implies an empirical test, content validity generally occurs using rational grounds or expert opinion to stake claims that a sufficiently representative sample of all possible questions has been included to reflect the breadth of the construct desired to be measured. However, both criterion and content validity models were deemed insufficient or at least to harbour significant limitations (Kane 2001). For example, determining a suitable criterion could be impossible in some cases, and content validity models are subject to confirmatory biases. As such, construct validity was presented as an alternative that emphasized the role of theoretical expectations in interpreting assessment outcomes. That is, if a theoretical model suggests that experts should perform better than novices, and if empirical data support that model, then claims of validity could be made. Construct validity, however, is dependent on having a well-established theory, a factor that serves as both its strength and limitation. In the absence of strong theories, in the context of competing theories, or in instances where it is not clear how to translate theory into something that can be assessed, validation efforts become unclear. This is one of the observations that led validity theorists to propose and elaborate an argument-based approach, one that could still take place even without a fully formed or formal theory.

In this brief summary of how validity has changed over time, one can observe a transition in ways of thinking that have become more complex and abstract, moving from efforts to prove concrete and specific theories towards empirical evidence generation and reporting of one's intended meaning and uses in an effort to warrant assertions in support of claims or counterclaims.

In health professions education specifically, these different philosophical positions all remain active, illustrating, in part, that application differences are reflective of distinct worldviews, rather than simply an evolution of thought with newer models necessarily replacing those that came before them. For instance, St-Onge et al. (2017), identified three distinct perspectives on validity that remain present in our literature. The first positions validity as a test characteristic that draws mostly on psychometric concepts; the second presents validity as an argument-based evidentiary chain that is described as "mostly psychometric", suggesting other philosophical assumptions have made their way into validation strategies; the third categorization describes validity as a social imperative, with the underlying philosophical position drawing more on expert judgment and social consequences of assessment than psychometrics. The authors of this work discussed how different users of validity may hold different views in what serves as legitimate conceptualizations of the concept.

All of this sums together to speak to the fundamental philosophical notion of 'Truth' and how one's perspective, be it explicit or not, drives application in assessment domains just as much as it does in the domains covered in other chapters of this book (see, for example, Chapter 12 on questions of Ontology; or Chapter 9 regarding social justice). Validity scholars have debated what validity claims mean in relation to truth with arguments generally falling within two views: those who wish to make claims about 'true beliefs' and those who wish to make claims about 'justified beliefs' (Kane 2013b; Borsboom and Markus 2013). In the 'true belief' position, validity obligates a degree of certainty that equates to truth. In other words, the effort of measurement is aimed at something stronger than simple justification because the latter is subject to making false or incorrect claims that can seem compelling but are based on faulty logic. In contrast, those who adopt a '*justified beliefs*' position, make no claims to truth, and argue that doing so is faulty in part because truth can never be known with certainty. While accurate conclusions are expected, truth is beyond what science or validity can promise. Values, more than truth, therefore, take precedence with the goal being to ensure simply that claims can be justified based on the best available evidence. These are two very opposing views with practical consequences in what can be claimed and what educators might need to be comfortable with and accept.

6.8 Discussion

Our aim in offering this chapter has been to describe how shifts in philosophical positions have informed health professions assessment and to outline implications of such shifts in perspective. We believe it important to be aware of the worldviews that have

led to particular efforts to identify and solve assessment problems both for the sake of guiding one's own thinking and to minimize communication problems between individuals. In most assessment contexts, philosophical positions play a fundamental role, yet they are too-often left implicit; that is, they inform the way assessment work is conceived, designed, deployed and appraised, but they are often not sufficiently attended to or spoken outright, leaving their implications not fully appreciated. The examples we have offered illuminate how worldviews have influenced, guided, and shaped the contours of assessment practices in the health professions over time along with the shift towards constructivist ways of thinking that has taken place in health professions education more generally.

The way we conceive of philosophical positions need not necessarily align with traditional philosophy of science paradigms (Chalmers 2013). While, at times, it may, we use the term more simply to represent variable yet inherent underlying assumptions, intellectual frameworks or fundamental vantage points that then inform how one determines the quality or suitability of assessment practices. New assessment ideas can come from anywhere and their utility, adoption and acceptance is dependent on, and determines what, we come to "know" about assessment problems and the solutions offered. Therefore, philosophical presuppositions have a role in assessment, but associated commitments need to be clearly attended to and marked beyond simply claiming their existence in assessment work.

When attention is paid to philosophical positions, this shines a new light on the thinking that guides our assessment practices. For instance, the utility of an assessment is more routinely seen now as an interaction between people, providing opportunities for a more fundamental focus on (and acceptance of) judgment, and a means of influencing learning through assessment. These philosophical shifts do not invalidate the use of techniques that have stood the test of time (given that it is how the assessment tools are used that matters), but they do necessitate a broadening of techniques and the criteria used to evaluate them, as illustrated through the development of programmatic assessment, and thinking of validity as argumentation rather than an entity that can be proven. Reflecting on the use of philosophy in assessment has meant assessment problems can be examined productively in new ways. Not as a means of giving up entirely on gains achieved through earlier ways of thinking, but by (a) critically examining the limitations of approaching assessment in a particular way (e.g., competence as a purely psychological trait to be measured without error), and (b) by providing insights for what solutions might be necessary if we are to optimize assessment designs and practice. There remain, however, many cautions to consider.

Despite the general shift towards constructivism/interpretivism, the assessment community is increasingly diverse in the way assessment scholars think about assessment problems and their solutions (Tavares et al. 2020). The transition is, therefore, likely better described as a broadening of the philosophical positions (including positivism, post-positivism, constructivism, and pragmatism) being used to interrogate assessment (and education), which sometimes creates conflict. On one hand,

such broadening of perspectives serves to advance assessment science, but on the other it can raise confusion and doubt regarding what might be best or even why one might approach assessment in a particular way at a particular time and place. Indeed, core features in assessment (e.g., conceptualizations of competence, the use of narratives, validity strategies) can be associated with a range of different philosophical assumptions and commitments, as illustrated in the examples outlined in this chapter. Increasing crosstalk is leading to uncertainties about how to proceed, fuelling legitimacy debates about methods without attention to underlying assumptions (i.e., logical incoherencies), the potential for problematic mixing of assumptions, different perspectives about what serves as high quality assessment (i.e., different understandings of the same concepts) and, therefore, threats to defensibility and validity. If validity is an argument, then cohesiveness is a core criterion through which it should be judged.

In the absence of the clarity of thought that can arise through cohesive understanding, unproductive debates about how best to proceed continue in part because there is diversity in the philosophical positions educators and researchers bring to assessment conversations without either revealing them or being clear about their meaning. As such, assessment scholars can find themselves talking about the same thing, sometimes using the same language, with very different intentions and underlying meanings. Making the underlying positions explicit permits a more dispassionate conceptual analysis and highlights ways in which one's decisions follow from assumptions and commitments. When done well, this yields scope and space for discussion and fruitful dialogue, opportunities for clarity, fair critical analysis, and careful evaluation of arguments.

As assessment continues to evolve, new solutions may experience difficulty if they are in tension with prevailing philosophical positions and may require some time until more aligned philosophical assumptions can be made explicit and resolved in the community. For example, consider the role of competence committees in assessment. This relatively new assessment model in health professions education, which has mainly summative functions—ultimately deciding on progression to the next phase of training or autonomy and social accountability goals—is challenged with several competing strategies and philosophical assumptions (Pack et al. 2019). Is their decision-making more defensible using statistical models (e.g., Bayesian techniques) to reach outcomes, or committee member judgment (Hauer et al. 2016; Zoanetti and Pearce 2020)? Are examinations of the degree of sampling in trainee assessment data intended to support triangulation or error reduction? Should competence committees seek and leverage subjective or objective data? Is the "collective" (i.e., assembling of information) better when it includes an assemblage of diverse or highly consistent views? Given the implications of the answers to these and many other questions, and the importance of competence committee work, it is vital that we understand how individual and collective philosophical positions shape their role, processes, and effects. If these positions are left implicit, assumed, or unattended to, it is unlikely

that clarity of understanding and consistency of practice within committee, let alone across institutions, could ever be achieved.

6.9 Conclusion

In summary, reflecting on the relationship between philosophical positions and assessment science provides opportunities and mechanisms through which miscommunication and insufficient practice might be resolved, permitting an open space for the identification and critical examination of guiding assumptions, commitments, and intellectual frameworks. Doing so can help the assessment community re-examine and reformulate existing and future assessment ideas in a manner that can allow complex assessment challenges to be approached in logical and abstract ways that enable practical issues to be more deeply understood and advanced. We have seen this in action in the ways thinking about the formative vs. summative distinction have changed, in how notions of programmatic assessment have evolved, in how the role of raters (assessors) has shifted dramatically, in the ways that statistical analysis is conceived, and in the ways in which argument about an assessment's validity are structured and advanced. Numerous existing and future areas of assessment can benefit from more routine consideration of applied philosophy. By examining philosophical positions in action through transitions in the way health professional education has treated our assessment practices, our intention is to advance the conversation on applied philosophy in assessment, stimulating theoretical and practical insights about assessment generally as well as better thinking (and, most importantly, more informed and deliberate conversation) about specific assessment problems and their potential solutions (Table 6.1).

Table 6.1 Practice points

1	Philosophical positions in assessment are sets of recognized assumptions and commitments or intellectual frameworks that offer lenses for examining health professions education's problems and solutions
2	Examining common assessment problems, applied solutions and features (e.g., the purpose of assessment, the role of assessors, and validation priorities) provide examples of philosophical influences and shifts in health professions education
3	Philosophical positions inform the way assessment work is conceived, designed, deployed, and appraised, but they are often not made explicit or sufficiently attended to, thus leaving their implications not fully appreciated
4	Regardless of the explicit intent of the assessment designer, the impressions of assessment recipients and the broader social context in which the assessment takes place matter and should not be ignored because they play a crucial role in determinations of assessment quality
5	Examining assessment through an applied philosophy lens promotes reflecting on the relationship between assumptions and assessment practice, can stimulate theoretical and practical insights about assessment, and generates more informed and deliberate conversation about specific assessment problems and their potential solutions

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Chapter 7
The Significance of the Body in Health Professions Education

Gabrielle Maria Finn, Frederic W. Hafferty, and Holly Quinton

7.1 Introduction

> The word body is very equivocal. When we speak of a body in general, we mean a specific part of the material, and set the amount which the universe is composed. But when we speak of the body of a man or woman, we hear any matter which is united with the soul of man.
>
> (Descartes 1649, 11)

The human body is the one thing we all have in common, and its death is our only guarantee. Long held as an object of significance and curiosity, the body occupies an ambiguous status—it is both what we are and what belongs to us (De Vignemont 2007). This ambiguity is a result of the nature of the body, one that is formulated in a number of binary oppositions:

> The body is both the Same and the Other; both a subject and an object of practices and knowledge; it is both a tool and a raw material to be worked upon. (Encyclopedia.com 2021)

Within health, it is both a lived body and an object of scrutiny.

In this chapter, we consider the nature of the human body and the different meanings and discourses ascribed to it. We describe our views on the various discourses of the body, namely the symbolic, aesthetic, sexual, and scientific. In doing so we explore links to philosophy, as well as pertinent considerations for contemporaneous

G. M. Finn (✉)
Faculty of Biology, Medicine and Health, School of Medical Sciences, The University of Manchester, Manchester, UK
e-mail: gabrielle.finn@manchester.ac.uk

F. W. Hafferty
Division of General Internal Medicine and Program in Professionalism and Values, Mayo Clinic, Rochester, MN, USA
e-mail: Hafferty.Frederic@mayo.edu

H. Quinton
Queens Road Surgery, Durham, UK

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curriculum development, and implications for healthcare professionals. We advocate for increased awareness of the imperative to evolve our body lexicon, the need for recognition of the feminist body, as well as inclusivity in bodies, and finally, we explore the potential presence of a hidden curriculum of bodies within health professions education.

7.2 What Is the Body?

What is the body? This seems like an obvious question. The human body is our physical substance. It is a mass composed of living cells and extracellular materials—classified into tissues, organs, regions and systems. The body has long been a subject of social and scientific fascination, critique, and condemnation, from the first documented dissections as early as the third century BCE[1] in Alexandria. Indeed, Anatomy is the oldest scientific discipline of medicine (Finn 2013, 2017). Yet, the body holds more than a biological significance.

One can consider the body within several discourses: symbolic; aesthetic; sexual; and scientific (Finn 2013, 2017). First, the body can be considered as a symbol of self—that is, the body as a being, as oneself. Second, there is the notion of the body within a scientific discourse, the object of scientific study, mapping, and investigation. In this discourse, the body is an eco-system, home to all the organisms that live within it, and on it. Next, we have the aesthetic, or artistic discourse, of the body, where the body is objectified, beautified, and revered for its physical significance. Finally, there is the sexual, or erotic, discourse of the body which concerns the significance of the body held by the beholder, self or other.

Of course, aside from these discourses, the body itself is often viewed as a work of art, with paintings of the body becoming mere representations of the innate aesthetic discourse of the naturally artistic human form (Finn et al. 2020). Considering the aesthetic discourse, the words of theatre critic Kenneth Tynan are poignant:

> The buttocks are the most aesthetically pleasing part of the body because they are non-functional … these pointless globes are as near as the human form can ever come to abstract art. (Tynan 1966, 432)

This quote, itself, provides an example of the simultaneously opposing yet complementary discourses that the body holds, the symbolic, aesthetic, sexual, and scientific.

As an object of philosophical thought, the most cited perspective in reference to the body is that of mind–body dualism, namely Cartesian thinking (Mehta 2011; Buckingham 2011). Dualism is the view that the mind and body exist as separate entities. Representing this philosophical position, René Descartes believed that there is a bi-directional interaction between mental and physical substances (Buckingham 2011). In this duality, the mind controls the body, but the body is also able to influence

[1] Before the Common Era.

an otherwise rational mind (Tim 2012), for example in an act of passion (Mehta 2011; Buckingham 2011). Descartes states that the mental can exist outside of the body, but the body cannot think. In this chapter we wish to consider the multiple, varied, messy meanings and significances of the body and how these meanings and significances manifest within a contemporary health curricula and clinical practice environment.

7.3 How Do We Perceive Our Body as Self? The Symbolic Discourse of the Body

When considering the body as self, we are describing two philosophical stances, bodily awareness and myness. Firstly, let us consider what philosophers call bodily awareness.

Bodily awareness is how conscious and connected you are to your own body. The underlying assumption is that we are aware of our body differently from other objects, such as a chair or stone. For example, we know we have a number of senses: sight; hearing; smell; taste; and touch (Smith 2006). Our senses provide us with a means by which to gather information concerning objects surrounding us, including our own bodies. As well as these five senses, we are aware of our own body in a unique way, set apart from the way we are aware of any other object. For example, we have an awareness of our position, orientation, movement, and size of our limbs, our sense of balance, and our awareness of bodily sensations including pains, pressure or temperature (Smith 2006). These features can be grouped together under the umbrella term of 'bodily awareness' (Bermúdez 2011). As Bermúdez notes, we are embodied, and we are aware of our bodies/selves from the inside through different forms of bodily awareness (Bermúdez 2005, 2011, 2015). Bodily awareness bears a special relation to self, and to self-awareness (De Vignemont 2020). Thus, it needs consideration within healthcare training due to being experienced differently by individuals. For example, communication skills are important when trying to elicit information from patients on how they experience themselves in any given environment.

Further to this bodily awareness is how we then perceive our body to be our self. This is the notion of 'myness', which can be defined as the property of belonging to the subject, and something that has attracted increasing attention in the literature (De Vignemont 2013, 2020). Thus, the central tenant is that one experiences one's body as one's own by virtue of having a feeling of 'myness' (De Vignemont 2020). For example, if we were to fold our arms, we identify the limbs as our own, while concurrently unable to misidentify the arms as belonging to someone else (Bermúdez 2005, 2011, 2015). Shoemaker (1968) noted that this bodily experience is resistant to error through misidentification relative to the person. "We experience our bodies as our own in a virtue of felt 'myness' that goes over and above the mere experience of one's bodily properties" (Bermúdez 2015, 643). Note, myness has also been contested in favour of bodily ownership (De Vignemont 2013).

7.4 Ownership and Disownership of the Body

Traditionally, in seeking health care, the lines or boundaries of 'myness' are breached—at least to some extent. While classes on patient communication or history taking may forefront the importance of 'the patient's story' or of 'the patient's experience', in point of fact, a good part of the diagnostic process requires both patient and provider to privilege or prioritize external measures of bodily properties including those that may be that may be beyond or external to bodily sensations. Yes, you can read in a textbook or class readings that much of what you need to learn about diagnosing a patient's problem can be attained via 'the history', but in practice this often is not what happens. Instead, we routinely turn to diagnostic and treatment modalities that allow 'us' (whomever) to 'read' the body in ways that might be considered by the individual undergoing such procedures as being quite strange, mysterious, or essentially not-of-me (e.g., alien).

We routinely—and have for eons—differentiate between 'symptoms' (what the patient reports) and 'signs' (what all our exogenous tools and tricks tell us)—and we prioritize the latter over the former. We even diminish the veracity or validity of symptoms by using phrases such as 'the patient claims', 'the patient reports' or 'the patient denies' in recording those elements of the 'story' that comes from the patient (after all, we don't write in the patient's chart that 'the test says' or that someone has a blood pressure of x/y 'according to the test').

In sum, and post that initial history gathering, one's sense of self as a biological system, including the uniqueness in which we are aware of our own bodies often is discounted (and routinely so). This includes any claim that we (as the patient and thus 'object" of such diagnostic and treatment modalities) might make (directly or indirectly) as to our uniqueness, given the dominating presence within clinical medicine of treatment protocols and practice guidelines.

Case Study 1: Bodily Disownership

Not all that long ago, one of the authors of this chapter had a foot injury (talus bone) and then subsequently broke a metatarsal bone in the same foot. Not long afterwards, they were taken aback when a family member pointed out that they were saying 'the foot' (as opposed to 'my foot')—all to no small embarrassment that they had been unconsciously externalising and disowning what might otherwise be considered an essential part of their anatomy.

There is a weird tension within Case Study 1 and the aforementioned examples. On the one hand, and on the personal responsibility side, there is the 'my' of 'my cancer' and, on the other, there is the disownership side of 'the cancer'. There is a significant body of literature on ownership and disownership. Briefly, here are four examples. Firstly, is the documented phenomena 'the alien hand sign' whereby patients experience a feeling of estrangement between themselves and one of their

hands (Goldberg and Bloom 1990). There are also instances whereby individuals experience their limb as alien yet still believe that it belongs to them (Sacks 1991; Cole 1996; De Vignemont 2007). Or conversely, individuals experience their limb as alien but then attribute the limb as belonging to someone else (Feinberg et al. 1998). Finally, Phantom limb syndrome, whereby an individual experiences sensations in a limb that has been removed, is a further example of the complexities of how differently the body resonates for people (Flor 2002). The aforementioned examples also link to bodily integrity, the subjective bodily experience of wholeness (Slatman and Widdershoven 2010). The learning for healthcare is that people own and disown their bodies in different ways. Healthcare practitioners should consider how patients own or disown their bodies and be mindful of their language with respect to bodily ownership. This is akin to the Körper-Leib distinction, translations of which include: "physical/material body' versus 'lived/animated body'; or 'objective body' versus 'subjective body' (Slatman 2019). Health requires awareness of the body as object and the lived body as a point of perception and agency (Slatman 2014, 2019).

7.5 The Scientific Discourse of the Body

The body has long been an object of study and a foundational element in the evolution of medicine as a discipline. Take, for example, anatomy, the study of the body as an academic discipline. Human dissection has long been the first encounter a health professions student has with the body. Often deemed a rite of passage, this interaction between the living and the dead is the subject of much anticipation, anxiety, and excitement. Cadavers are regarded by some as 'the first patient' or by others as 'the silent teacher'. For students training to save, improve, or bring new life into society, this early focus on cadaveric form seems a juxtaposition. Further, it is rare that the patient in clinical practice is, in fact, deceased. The scientific discourse of the body risks objectification and depersonalisation—concerningly, the potential is to disempower patients—the owners of the body. Further, the scientific discourse of the body and its associated subjectification can result in alienating learners and patients alike. This can range from tacit messaging to the intentional exclusion of different types of people, and thus different bodies, within both the anatomical and clinical arenas. We will discuss this in our subsequent considerations of the hidden curriculum of the body.

Through the scientific study of the body, and, indeed, through the diagnostic lens of clinical assessment, the body is at risk of objectification. Much of health professions education calls for this objectification as both a desired end point of diagnostic and treatment work, and as a desired cognitive and emotional state of the worker. Within social philosophy, objectification is linked to disavowing the humanity of others. This clearly opposes the patient-centric approaches advocated within health care settings, or, by extension, learner-centric approaches advocated for within modern health professions education. Such objectification could be considered directly at

odds with the biopsychosocial model[2] utilised within clinical medicine and within curricula.

7.6 Blurred Boundaries—Buying Bodies

Perhaps the most omnipresent discourse, the aesthetic of the body, unites the discourses we describe. Whether representing the body scientifically (for example, in biological diagrams), visualising the body erotically, or considering how we look to both ourselves and others, the aesthetic discourse is present. Now more than ever, people pay top dollar to look good—this can range from purchasing apps or watches to track biometric data for fitness purposes, to more invasive cosmetic surgery procedures.

Concerning the relationship between the aesthetic discourse of the body, normativity, and health, two pertinent examples offer different views on the relevance within healthcare. Firstly, biometrics and cosmetic procedures, and secondly, artistic representations of the body within the scientific literature.

Biometric data is available in abundance—you can buy a piece of yourself (Alterman 2003; Tanwar et al. 2019) and quantify reality (Ghilardi and Keller 2012). There are commercial and medical purposes (which are not mutually exclusive). Consumers can buy a view inside their own body from blood tests for thyroid function to smartwatches that track heart rate, steps, or food macronutrients. As well as the commercial access to the body, potentially capitalising on aesthetics, there are also helpful innovations such as continuous blood glucose monitoring with smartphone alerts. This instant access to the body changes the relationship between us and our bodies—there are legal, ethical, personal, and social implications too (Alterman 2003; Tanwar et al. 2019). There are positives, with increased health and fitness, but dangers with bountiful data that people may not understand or know the 'normal' parameters for. Further to this is the increased risk of social exclusion based upon biometric identity data, or a more pertinent example of digital immunisation passports. As such, the duality of the body as object and as self becomes blurred—for example, with the need for ethical guidelines for the timing and use of data that promote equity, public health education, anti-discrimination, privacy, and flexibility (Jecker 2021; Osama et al. 2021). Similarly, there is now shopping mall access to aesthetic procedures such as Botox, fillers, and other more invasive surgical cosmetic procedures. Again, the scientific and aesthetic discourses of the body have become blurred—there is no longer a dichotomy. The desire to be attractive is recognised for attracting interest, as well as economic and social necessity (Aufricht 1957).

Bodily (anatomical) variation is normal, entire atlases are devoted to documenting such variation (Acland 2003; Bergman 2021), yet 'normal' prevails. What does

[2] The biopsychosocial model was first incepted by George Engel in 1977. It is an approach or model which considers and examines the interconnections between biology, psychology, and socio-environmental factors.

normal mean in this context? It means the archetypal representation of something that does not exist within the variability of 'real life'—often and traditionally represented within the archetype of the white male. For example, Cardiopulmonary Resuscitation (CPR) mannequins are predominantly white. So, too, are human biology posters. When inclusivity of bodies is sought, it still is limited and typically manifests a black-or-white dichotomy. However, the field of dermatology has shown some progress away from the narrow demographic of cadaveric and medical models in the strive for decolonisation of health services and portrayal of the variety of skin tones in the healthcare curriculum (Finn et al. 2022). This deficit is being slowly closed with the publication of texts like that by Dr Malone Mukwende, a medical student at St George's University of London who co-authored, 'Mind the Gap', a textbook including imagery and descriptions of clinical signs and symptoms in black and brown skin (Mukwende et al. 2020). Alternatively, Professor Susan Taylor, who published 'Dermatology for Skin Color' warned against the existence of a separate textbook, reporting this as encouraging 'otherism' (McFarling 2020). Moving forward, when we represent the body in textbooks and cadaveric material, teaching staff should reflect, research, and act to provide and incorporate curriculum and core texts which educate students in disease manifestation, diagnostic skills, and health promotion to serve the ethnic mix of the current population. This may take the form of auditing and editing teaching materials with bioinformatics and population data. It is important to note that, throughout this process, representatives of diverse ethnic groups should be consulted before curricula innovations are implemented.

7.7 The Feminist Body

> To men a man is but a mind. Who cares what face he carries or what form he wears? But woman's body is the woman.
>
> (Ambrose Bierce 2008 [1906], 15)

Within all the discourses of the body there is a gendered body. Historically, there has always been a significant focus on women's bodies as 'other' (for more on this, see Chapter 9, which focuses on women as the 'Other'). Traditionally women's bodies were the subject of art, the subject of scrutiny, and the subject of objectification (Lennon 2018). There was recent outrage when the Royal College of Midwives omitted women and postnatal mother from an infant sleeping leaflet, instead, using a collective "postnatal people" in an attempt to be gender inclusive (Carr 2021). Public fury on social media was rooted in the omission of the words 'women' and 'mother', perceived as a reductionist oversimplification and act of cancellation. Although gender-neutrality is not an act of reduction, removal of the word mother was interpreted as misogyny.

From a philosophical point of view, what it means to be human and what the body is has long been viewed as male (Buckingham 2011). De Beauvoir documented a narrative of the body as experienced throughout the different stages of a woman's

life (De Beauvoir 1973; Dietz 1992; Buckingham 2011; For more on De Beauvoir's other works, see Chapter 4). She noted that during childhood the experiences of girls and boys are very different—young girls are trained into a different way of inhabiting their bodies. Distinguishing the changes in the body during puberty, for example, she notes the body becomes a source of horror and shame for girls. They become aware of their lack of physical power and thus begin to exhibit an associated timidity. De Beauvoir proffers an account in which young girls undergo a training in bodily habits which structure the possibilities for interaction with their world. Critics of de Beauvoir lambast her naive use of existentialism, a philosophical approach which emphasises the existence of an individual person as both a free and responsible agent able to determine their own development through acts of the will (Lennon 2018). However, Le Doeuff (1980) argued that de Beauvoir made three notable transformative thoughts with respect to existentialism. Firstly, that she overcomes the limitations of the concepts of woman as object and the Other (La Caze 1994). Secondly, her thinking makes it possible to theorise oppression by taking into account women's concrete situation. Finally, she eliminates images of the female body as 'holes and slime' that are proffered in Sartrian thinking (La Caze 1994). These transformative thoughts that de Beauvoir presents still frame our philosophical thinking in regard to the female body today.

Acknowledging the feminist body is important within healthcare education. The notions of shame, power, inhibiting bodies, and scrutiny noted by de Beauvoir all present challenges that impact on the way the female body is presented in education and healthcare. An example of this can be demonstrated in reference to the field of obstetrics and gynaecology.

Case Study 2: The Feminist Body and Our Body Lexicon

'Geriatric-primigravida' is a term still used to describe a pregnancy when the pregnant woman or trans-man is over the age of 35 years (Royal College of Obstetricians and Gynaecologists 2013).

Emily is 36, she is pregnant for the first time and is currently 14 weeks gestation. She has visited her General Practitioner multiple times with pelvic cramps and some spotting (light bleeding). Ultrasound scans and antenatal tests have revealed a healthy pregnancy with no current complications. She is fit and well. Given her repeated attendance, her General Practitioner asks if she is anxious and she sobs that she is too old to be pregnant that she was referred to at her antenatal appointment as a 'geriatric-mother'.

Let's consider Emily further. In the UK, the Office for National Statistics (ONS 2021) quote 65 years of age as being 'old age' and 'oldest-old' over 85. Old, elderly, and geriatric are interchangeable words. Age is associated with functional decline,

but the terms 'geriatric' and 'elderly' don't seem to be appropriate for a 36-year-old as the old do not (apart from extremely rare exception) bear children. While there is, undeniably, a continuum of risk associated with pregnancy as maternal age increases (Royal College of Obstetricians and Gynaecologists 2013), the wording and terms used to describe the functions of the female body should be used with the same sensitivity as discussing a cancer diagnosis or approaching mental health problems. The statistics support this call for terminology change—geriatric/elderly mother labels should be made redundant in modern healthcare (Spalding 2021).

A further example of how women's health has long been problematised, includes the taboo and stigma of menstruation (McLaren and Padhee 2021; Thapa and Aro 2021; Babbar et al. 2022). The menstruating female body is no longer deemed sexual, and has even been deemed 'ill' (Leviticus 20:18) (Olyan 1994; Wenham 1979). Menstruation has been linked to impurity and a lack of cleanliness—here we see our framing of the symbolic body. Such notions of uncleanliness are well documented within religious texts (e.g., the Bible), such as Leviticus (12:2) who problematises post-partum bleeding, and menstruation (15:20). Historically, women have been labelled as 'unclean'.

In their book "The Revolting Self", Powell et al. (2015) suggest that revulsion is usually developed from admonishment by caregivers to protect a child from disease or harm. Revulsion to one's own body is thought to be an 'undervalued cause of depression' and helps to explain avoidance of health screening behaviours rooted in a negative a-posteriori view of oneself. Other phrases and visual descriptors related to women's bodies in medicine carry subversive disdain of female bodily function. This disgust has historically been applied to menstrual blood. Menstrual blood is rarely shown accurately—as a shade of red in advertising, but the same colour as urine in infant nappy/diaper advertising. Menstrual blood is not akin in any way to urine and advertisement messaging is minimising uterine function. Bleeding is messy, but menstrual blood is portrayal is tightly and neatly controlled. Sadly, a quarter of women report not understanding the mechanism of their monthly cycle and around a fifth are too embarrassed to talk about it to close family friends or a partner (ActionAid 2017). Anecdotally, one author of this chapter notes that in their clinic patients often apologise before they talk about menses. Diminishing or hushing dialogue of the labia, vagina, and uterine function prevents empowerment. Slang terms pertaining to female genitalia are still considered some of the crassest in the English language; similarly, a cervix is sometimes referred to as 'incompetent' and pregnancy can 'fail to progress'. Terminology surrounding penile is a lot less fatalistic when it comes to erectile difficulties, suggesting that the penis is 'dysfunctional'.

Equality and empowerment are not achieved if female body and function lexicons are fatalistic or filled with outdated negative connotation. Healthcare teaching needs to highlight these repressive or minimising descriptions of the value, age, and bodily fluids of the human body, with menstruation education and an empowered lexicon which is both patient-centred and accurate in reality of the body's function.

7.8 Sexual Bodies

Consideration of the sexual discourse of the body presents a multiplicity of challenges, including but not limited to the multiple meanings of sex, the conflation of sex and gender, and the taboo nature of the subject. Before considering the sexual discourse of the body, we must consider the terms pertinent to this discussion. This section considers how we define sex, gender, sexual orientation, and sexuality for the purposes of this chapter and as parts of the sexual discourse of the body.

7.8.1 Sex

One definition of sex refers to the physical differences between people who are male or female (Newman 2021). There are also people who are intersex. A person's sex is assigned at birth—typically based upon their physiological characteristics, including their genitalia and chromosomes (for an alternative view, see Chapter 10). This assigned sex is called a person's 'natal sex'. Sex is typically considered binary, neglecting to consider intersex. However, recent debate has surrounded sex with the idea of two sexes being viewed as simplistic. In a well-cited paper, Ainsworth (2015) describes how "biologists now think there is a wider spectrum than that" (288).

7.8.2 Gender

Gender is how a person identifies. Unlike natal sex, gender is not binary, rather it is a broad and fluid spectrum along which a person may identify. When a person identifies as the same gender as their natal sex, they are cis-gender. Gender may differ from natal sex and could include transgender, nonbinary, or gender-neutral. Further, gender also exists as within a social construct, for example with gender roles or norms (Newman 2021). Newman (2021) describes these as the socially constructed roles, behaviours, and attributes that a society considers appropriate for men and women.

As our understanding of sex and gender evolves (see Chapter 10 for a thorough discussion of this), our lexicon is failing to keep pace with this evolution (Finn et al. 2019, 2021). As Lazarus (2021) describes, within healthcare settings and healthcare education, there is an increasing need to find terminology that accurately reflects the bodies it represents. Yet, healthcare continues to struggle to describe bodies outside gendered terms. Training healthcare professionals to recognise that expression of gender, sex and sexuality may not align to our traditional medical lexicon is of paramount importance.

7.8.3 Sexuality

Sex embodies a multiplicity of purposes, including pleasure, procreation, the formation and definition of relationships, the communication of norms, values, attitudes, and expectations. Sex is also the provision of a major mechanism of subjection, abuse, and violence. Sex is interwoven with sexual orientation. Sexual orientation is a person's identity in relation to their inherent or immutable enduring emotional, romantic, or sexual attraction to other people. It is defined in relation to the gender or genders to which they are sexually attracted.

7.8.4 Implications for Health

Historically, within western philosophy, sex and sexuality have received limited attention. Where it has been discussed, it has been problematised and denigrated. Literature notes that both its pleasures and power can ruin lives. The arguments that sex should be for the purposes of procreation only, and the links to morality, have resulted in a topic that even present-day remains taboo. Within healthcare, this is problematic. For example, avoidance of cervical screening, or a delay or failure to report medical problems pertaining to the bowel and genitourinary area, are well known. Furthermore, it is well established that health inequalities exist for many marginalised groups, including the LGBTQIA+ community (Finn et al. 2021), particularly with, for example, the stigma associated with sexually transmitted diseases or discussing reproductive organs.

We teach communication skills extensively about the hidden agenda and the 'by the way' last minute raising of sexual, genital, or bowel and bladder concerns after a person has ascertained how accessible a clinician is—having built up a rapport over a consultation. Our self-concept including myness develops over time but is influenced by our interactions with others and the beliefs held about our characteristics; our self-esteem, ideal self, and self-image (Baumeister 1999; Argyle 2017).

7.9 The Hidden Curriculum of the Body

As previously discussed within this chapter, students will encounter the body in many forms within their training as health professionals. These forms include bodies (or body parts) as pathological or anatomical specimens, (e.g., cadavers), graphical representations of bodies or body parts via media as such as videos or still images, computer simulations, and via living forms such as simulated patients, healthy volunteers, peers, faculty (as role models), and actual patients.

There are numerous factors and interactions (e.g., communication, logistics, physical examinations, curriculum planning), each with the potential to unfold across an array of formal (intended and structured) and other-than-formal (unintended and unstructured) teaching–learning opportunities. Thus, there is the *potential* for discordance between learning that is intended (often as set by faculty or the training institution) and that which is experienced (by learners). In short, there can be tension between 'the talk' and 'the walk', or between 'policy' and 'practice'. Within the field of education, and in referencing these interstitial spaces, the term most frequently used is the hidden curriculum—which refers to the tacit, implied, unwritten, unofficial, and often unintended behaviours, lessons, values, and perspectives that students learn during their education (Hafferty and Finn 2015; Finn and Hafferty 2020; Matthan and Finn 2020).

An example of a hidden curriculum of bodies is the selection of 'healthy volunteers' or 'simulated patients' within a class on communication skills or diagnostics. We begin by asking whether the bodies learners are being presented reflect the full range of what they will encounter in practice or whether there is a backstage selection process that isn't being made explicit to these learners? Are there screenings or other manipulations so as to present learners with an 'optimal' body type? Are volunteers or actors with slender bodies chosen more frequently? Does the historic white male archetype remain omnipresent? Are there cultural issues at play in the recruitment of 'practice volunteers' that are never spoken about? Perhaps there are implicit screenings that ensure the simulated patients students examine present no 'unreasonable' diagnostic challenges (whether that be for students or the course director or faculty) …

Let's take, for example, arranging simulated patients for a teaching session on the respiratory system. Firstly, using a cis-female patient with breast tissue might be viewed as problematic as the breasts may block access to the lungs. Secondly, teachers may (wrongly) worry the female breast presents the risk of sexualising the context. Thirdly, there is added, and potential, inconvenience associated with a perceived necessity to arrange for chaperones if a female is chosen as the volunteer for a respiratory examination. All these issues may be taking place 'backstage', perhaps even unconsciously, for those arranging the simulated exercise. The subsequent—and hidden—arrangement is that faculty may then opt to utilise male patients or female patients with smaller breasts.

This background manipulation or screening by faculty also extends to the selection of imagery within the curriculum, as discussed by Matthan and Finn (2020; Finn and Matthan 2019). They report a historic absence of variation in presentation of different body morphologies, races, and the spectrum of gender. In digital teaching materials, for example, there are few representations of anorexic bodies, of morbidly obese bodies, of non-white bodies, of female bodies, and of trans-gender bodies (Finn et al. 2022). Instead, what is on offer is, at best, an idealised modal body that represents the middle of the spectrum, and at worst a white male archetypal representation. Learning from idealised versions of bodies runs the risks of perpetuating health inequalities.

We risk students seeing bodies in a clinical environment that they have not seen in training. We risk a hidden curriculum of body normalcy, one in which maleness and athleticism gets privileged. We risk a limiting students' thinking on the body to the binary and to the heteronormative.

Finally, it is important to note that the hidden curriculum of medicine has been misrepresented as space that: (a) includes 'hidden agendas' and thus is driven by intentional deception or backstage motives (the hidden curriculum is more a sociological than psychological construct—although see one exception below); (b) exists only to highlight discordance or to shine a light on negative behaviours and professional misconduct (there can be concurrence between the other-than-formal and formal dimensions of organisational life; (c) is singular (hidden curriculum) and thus unidimensional rather than plural (hidden curricula); (d) is something that is experienced by all individuals in the same way (while there may be common messaging driven by structural or cultural factors, this messaging may not be unilateral and homogeneous; (e) that all disjunctions between the formal and other-than-formal can be resolved by transferring tacit learning into formal instruction; and (f) can be deliberately manipulated to transform what has been tacit and informal into lessons that are and surreptitiously manipulated towards desired ends—something that has been termed 'teaching by stealth' (Aka et al. 2018).

7.10 Conclusion

To summarise, and on a surface level, the body appears conceptually simple—a living organism composed of the Cartesian mind–body dualism. When it is broken, we seek healthcare, often within this dualism (e.g., for mental health *versus* physical health reasons). What we have emphasised in this chapter is that such representations and reproductions within healthcare and healthcare education reflect this rather narrow view of the body. In such ways, the scientific discourse of the body often neglects to consider the symbolic, sexual, and aesthetic discourses. Awareness of such discourses and their potential significance for individuals could go some way towards improving healthcare and reducing the inequality experienced by certain groups based upon having certain bodies, for example female or black bodies. As societal views of the body evolve, our lexicon and teaching of the body within health need to keep pace. We advocate for a more inclusive approach to how the body manifests within healthcare curricula—noting the spectra of gender and race, in particular. For too long, the body has been considered male, with females dismissed as 'other'. We started with the idea of mind–body dualism, and as we know, dualism is reflected in all sorts of things, however, the discussions within this chapter have shown that the body is more complicated and that dualistic framings should be a thing of the past. Healthcare should not default to a scientific view of the body as object (Table 7.1).

Table 7.1 Practice points

1	When developing curricula, create space for consideration of the discourses of the body. Acknowledging that dualistic thinking about the body is no longer a useful lens—the body is too complex for such a reductionist view
2	Advocate for the critical engagement of health professionals and students with their own orientation towards their body—noting that individuals differ
3	Normalise the sexual discourse of the body with health professions education and healthcare delivery. Only through open discourse will the sexual discourse no longer be so taboo
4	Campaign for the use of inclusive language and the need for an evolving body lexicon, particularly with respect to biological, genetic, and anatomical terminology. Educate health professionals and students on the need for a patient-centric lexicon—explaining the nuances and being mindful of the challenges of labelling, diagnostic or otherwise e.g., geriatric mother, obese etc.
5	There is potential for a hidden curriculum of body normalcy or body optimisation for certain educational activities, for example in the use of subconscious or deliberate backstage selection processes of cadavers, simulated patients, or healthy volunteers. Awareness of the potential for tacit messaging is paramount

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Chapter 8
The Philosophy of Education: Freire's Critical Pedagogy

Jennifer L Johnston, Nigel Hart, and Annalisa Manca

8.1 Introduction

> We have to go from what is essentially an industrial model of education, a manufacturing model, which is based on linearity and conformity and batching people…We have to recognize that human flourishing is not a mechanical process; it's an organic process. (Robinson 2006)

Adopting a critical pedagogy offers a radical reorientation for health professions education. Focusing on power and structural inequalities, it poses a strong rebuttal to conservative voices who maintain that medicine is and should be apolitical. First theorised in the 1960s by Paulo Freire, a Brazilian educationalist drawing on Marxist tradition (Freire 1972), critical pedagogy has been highly influential in other social sciences, especially in Latin America, but has been little known in Anglophone medical education to date (Tarlau 2014; Halman et al. 2017). It was first used to advocate literacy education among those in poverty but has been translated to multiple contexts and extended by other theorists (hooks 1994; Giroux 1985).

Denouncing mindless *banking models* of education, Freire locates our very humanity in the development of *conscientização (critical consciousness).* This is a phenomenological way of being *in* the world and *with* the world that flattens power structures and empowers learners to address inequality (Freire 1972). The world of

J. L. Johnston (✉) · N. Hart · A. Manca
Centre for Medical Education, Queen's University Belfast, Belfast, Northern Ireland, UK
e-mail: j.l.johnston@qub.ac.uk

N. Hart
e-mail: n.hart@qub.ac.uk

A. Manca
e-mail: amanca01@qub.ac.uk

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medical education is strongly influenced by a strongly positivist biomedical tradition, the clinical gaze (Foucault 2003), and societal privilege, so that the development of critical consciousness offers an important means of addressing social justice in healthcare (Ross 2015). Beyond that, it offers individuals a profound intellectual awakening through the transformative development of *conscientização* (Smith 1976).

We introduce critical pedagogy's key concepts, discuss its genesis, evolution, and future, and provide a case study into its practical application within undergraduate education in a General Practice (GP) context.

8.2 Banking Models and Industrialised Education

School systems in the global north are broadly a product of industrialisation, driven by the twin masters of efficiency and profitability (Welch 1998). Practical examples include the classic rows of identical desks, uniforms, rigid curricula with little space for creativity or individuality, and teachers whose dual role is to control and instruct. All of this results in learners moulded towards a place in society predetermined by characteristics such as race, class, gender, and other structural constructs of power.

Freire called this type of education a *banking model*: students' minds are empty, passive 'bank accounts' into which teachers make 'deposits' of pre-approved knowledge. A good student in this conception accepts a subordinate position and unquestioningly takes care of their deposits:

> The teacher teaches and the students are taught;
>
> the teacher knows everything and the students know nothing;
>
> the teacher thinks and the students are thought about;
>
> the teacher talks and the students listen -- meekly;
>
> the teacher disciplines and the students are disciplined;
>
> the teacher chooses and enforces his choice, and the students comply;
>
> the teacher acts and the students have the illusion of acting through the action of the teacher;
>
> the teacher chooses the program content, and the students (who were not consulted) adapt to it;
>
> the teacher confuses the authority of knowledge with his or her own professional authority, which she and he sets in opposition to the freedom of the students;
>
> the teacher is the Subject of the learning process, while the pupils are mere objects. (Freire 1972, 68–69)

Banking education is a means of oppression, preventing the development of creative or critical thought so that learners become 'automatons'. Freire echoes Gramsci's concept of hegemony- that is, power exercised by coercion rather than force, in which education plays a key role in keeping the proletariat compliant and subdued (Gramsci et al. 1971). Gramsci called the subsequent lack of consciousness of oppression *manufactured consent*. A common and persistent example is that

of uncritical colonising curricula, where education is used even in current times to explicitly suppress First Nations peoples (for example, in North America and Australasia) eliding the experience of those oppressed by hegemonic colonial attitudes reflected in schools, colleges and universities (King 2021; Canuto and Finlay 2021; Woldeyes and Offord 2018).

Underpinning banking models is a positivist epistemology assuming education to be value neutral and removed from moral or political influence (Giroux 2011). A focus on objectivity means that learners are authoritatively presented with clean and uncontested 'facts'. Education in this sense exists to *reproduce* discourses and practices of power, and to minimise dissenting voices. Teachers who unthinkingly reproduce generational power structures in this way were referred to by Freire as 'bank clerks' (Freire 1972).

8.3 Relevance to Medical Education

Our focus here is on the training of doctors, but we hope that many of these concepts are resonant and transferrable to the education of other healthcare professions.

Multiple social, educational and clinical discourses influence medical education. Neoliberalism is one of the most important: the current dominant economic ideology of the global north, it is the natural capitalist successor of early industrialism. Its central tenet is the permeation of free market forces and individualist discourse into all aspects of society (Fine and Saad-Filho 2016). Since the 1990s, neoliberal discourse has infiltrated the university sector, leading to repeal of grants, their substitution with loans, and substantial increases in university fees, while academic freedom of thought has become constrained by the need to remain appealing in the market (Vernon 2018). In the neoliberal university, students are consumers, research is a commodity, and staff are trading pieces in a global capitalist game.

Throughout tertiary education, elements of banking models combine with neoliberal rhetoric to define students' learning experiences. Tightly defined admissions procedures (never more so than in medical schools) make entry requirements less attainable for those without privileged backgrounds. In large lecture halls, the banking model looms large as lecturers make deposits into students' accounts. At graduation, traditional academic dress marks hierarchical status, yet this apparent meritocracy is subject to significant structural bias (Zivony 2019).

Medical education is not exempt from these discourses (Mayes et al. 2016). Doctors occupy a high-status position, and their training is a competitive industry in itself. Neoliberal trends fuel the cultural dominance of a privileged few, with access to medical training from socioeconomically deprived populations inevitably restricted as costs become prohibitive (Moberly 2016). Emphasis is on individual accountability rather than creative team working. Curricula are tightly regulated through industrial-level assessments (General Medical Council 2021).

As early as 1908, Flexner problematised industrialised medical education:

> Each day students were subjected to interminable lectures and recitations. After a long morning of dissection or a series of quiz sections, they might sit wearily in the afternoon through three or four or even five lectures delivered in methodical fashion by part-time teachers. Evenings were given over to reading and preparation for recitations. If fortunate enough to gain entrance to a hospital, they observed more than participated. (Cooke et al. 2006, 63)

It is not difficult to interpret Flexner's comments as a form of banking. Despite Flexner's negative commentary, this pedagogical approach continues to have traction (Halman et al. 2017). When combined with the strong positivist influence on medicine from bioscience, medical students are afforded a position as passive recipients of information without agency, humanity, curiosity, or creativity. A key example is the current dominance of *competency-based medical education* (CBME).

With a well-intentioned aim of improving and standardising approaches on patient safety and care, focusing on the needs of communities, CBME is an outcome-oriented approach to learning which dominates much of medical education in the global north. With an initial focus on patient safety, the CBME movement has become problematic through its rigid implementation in teaching, assessment, and professional development (ten Cate and Billett 2014). Examples of competency-based curricula include Canadian CanMEDs (Royal College of Physicians and Surgeons of Canada 2021) and the UK Outcomes for Graduates (General Medical Council 2020).

CBME curricula are complemented by assessment, often through the hegemonic Objective Structured Clinical Examination (OSCE). We have extensively criticised both OSCEs and their close cousin simulation education for having expanded beyond their original remit (Johnston et al. 2020; Reid et al. 2021) and for drawing on industrial models, for example with simulated patients and mass testing of students regimented by regular bells (Gormley et al. 2021). In the UK, the national Medical Licensing Exam will be introduced in 2024 and will consist of a large-scale OSCE (General Medical Council 2021). Yet, this one-size-fits-all approach pays no heed to local community needs or contexts. OSCEs and simulation education have unintended consequences for learning, too, in becoming the only forms of medicine which students will know: clean cut, with the clinician in control and the patient following an obedient script (or indeed, replaced by a mannequin). Students, too, in the role of doctors, follow unconvincing set scripts leading to 'shotgun' answers. Simulation suites ensure that a deadly clinical encounter can simply be reset, and the game started from scratch with no casualties (Johnston et al. 2020). It is our position that this in no way prepares students for dealing with humans or the messiness of real-life clinical practice, unless countered by a strong critical and humanistic focus on learning in the workplace.

8.4 Rejecting Banking Models

Freire's critical pedagogy explicitly links individuals with their contexts. Following the existentialist thinking of de Beauvoir and Sartre (de Beauvoir 1997; Sartre 1992),

Freire held that meaning does not exist outside phenomenological experience of the world. Without the ability to critique and be fully open to the world, banking models of education end with learners unable to fully achieve their human potential. Yet the need to become fully human is an *ontological vocation*, making banking education nothing short of a dehumanising endeavour (Freire 1972). See also the relevant chapters on *Ontology* (Chapter 12) and *Technology* (Chapter 17).

Translated to medicine, banking approaches stymie our full potential as humanistic, rather than purely technical, doctors. The everyday dialogues of teaching and learning offer a means of reproducing or resisting these power relations. Critical pedagogy is Freire's call to arms for educators to engage in *counter-hegemony* against the reproduction of oppression (Gramsci et al. 1971). He offers the alternative of *problem-posing education*: students and teachers engage in *reflection and action* through constant formative dialogue. This intersubjectivity allows both to develop agency and criticality, while recognising each other as conscious human beings (Smith 1976).

Problem-posing education simultaneously shifts the emphasis from positivism to co-construction and levels the power gradient between student and teacher. Learning becomes bidirectional through dialogue (Bakhtin 1981). Education is openly acknowledged as inherently political. Both participants (learner as teacher, and teacher as learner) become cognisant of oppression, including their own positionality regarding oppressive practices. Problem-posing education allows the development of a theory of mind- a meta-consciousness of the conscious existence of oneself and others.

8.5 Raising Critical Consciousness in Medicine

Developing critical consciousness does not imply a single threshold event but rather ongoing real-world practice (*praxis*). Education is therefore a *practice of freedom,* whereby transformation of self and society ensue.

Critical pedagogy is not yet particularly well known in medical education; our 2019 scoping review found only 20 relevant papers. We identified 4 key themes: social awareness, cultural awareness, political awareness, and awareness of educational dynamics. These represent important areas where problem-posing activities can be developed. Critical pedagogy embodies *action*, not just thought, and so has real-life pedagogic applications in clinical workplaces as well as in universities (Manca et al. 2020).

The project of introducing *conscientização* to medical curricula is not without challenge, however, since it constitutes a form of counter-hegemonic practice defined by action against mainstream hegemonic assumptions. Many healthcare educators, particularly clinicians, are in their second career. Unless they have been exposed to social science, they may bring to education a constrained position of naïve realism and biomedical positivism. Taking on a critical stance is a paradigm shift (a foundational shift in concept and practice) for these educators, and one that they are therefore

unlikely to take spontaneously. Students, meanwhile, may not have experienced problem-posing education. They, too, face a paradigm shift in becoming critically conscious. Yet the benefits of doing so include a shift away from neoliberal influence and back towards medicine's social contract. Healthcare inequalities may be better addressed by humanistic doctors who are more than merely excellent technicians; within empathic dialogue, clinicians may come to an understanding of the embodied experience of sociocultural determinants of health and develop strategies to treat people rather than illnesses. Such doctors learn to construct themselves as much more than Foucault's seminal clinical gaze (Foucault 2003), embracing the ontological vocation of becoming fully human.

In our case study, we draw on empirical work undertaken for Dr Manca's doctoral thesis to illustrate how critical consciousness can be enacted in medical education. She conducted ethnographic observation of an exemplar of UK university-based undergraduate medical education in a general practice (GP) in 2018–2019. It becomes evident that GP educators cultivate students' understanding by focusing on values, rather than just competencies. The pursuit of critical consciousness can be seen not as linear, but as a *dialectic* process. Educational practices can be seen to be potentially transformative for both learners and environments, with GP teachers reaffirming their own clinical vocation.

8.6 Case Study: Enacting a Critical Pedagogy Within Undergraduate GP Teaching

Context: The GP course explored here was a four-week module in year four of an integrated, systems-based, five-year curriculum. This was the first substantial introduction to GP work in students' experience to date. An introductory central teaching week was followed by three weeks in practice. Subjects taught formally included the philosophy and practice of primary care, and how it differs from the secondary care settings which students were more used to. A substantial review of the course in 2017–2018 recognised and enhanced the inherent orientation towards critical consciousness, mainly allowing more space for discussion and reflective dialogue.

Research questions: We focused on exploring the following elements:

- How teaching is structured, and what educational strategies GP teachers used.
- How knowledge is enacted throughout educational practices and pedagogical relations.
- How GP teachers managed the dynamics of power and authority.
- How GP teachers attended to conflict within teaching.

8.6.1 Integrating GP Work into Existing Knowledge of Clinical Practice

GP teaching gave students an understanding of primary care as it was enacted in teachers' educational and clinical practices. Sessions were structured to facilitate students' gradual entry to primary care, referred to as 'GP Land'. This mild idiosyncrasy established general practice as an autonomous and boundaried entity outside of the hospital system in which students had spent most time to date. Teachers portrayed GP as an enclosed domain which integrated interprofessional practices while maintaining a core philosophy in which the axiology was relational care.

8.6.2 External Integration: Moving Past Positivist Bank Deposits

Some sessions built on previously acquired knowledge, challenging assumptions while transferring knowledge to the new context. Students were introduced to wider sociocultural, political, and historical influences on general practice, including legislation, deprivation, class, race, gender and immigration. These were not necessarily known to students. Exploring these influences constituted an early challenge to the positivist biomedical model of medicine.

8.6.3 Education in Dialogue

The first formal educational activity of the course, undertaken in the university, was one of *disruption.* Students (around 40 altogether) were assigned to groups of 7/8 people and asked to physically move position within the room, lifting their chairs and replacing them in small circles. At the end of this operation, the room format had completely changed from typical lecture style to 6 circular formations distributed across the room. GP teachers explained that students would work in these groups throughout the period of formal teaching. The first task was to find a name for their "GP Practice"- that is, their group. By engaging students in disrupting the expected activity of a didactic teaching session, students were brought to a temporary shared identity as a 'Practice'. This physical and mental shift, combined with contextual discussion of GP work, encouraged them to begin to empathise with. This simple exercise explicitly challenged banking education and afforded learners an active role. A pedagogic intention to mitigate hierarchical relations between teachers and students was expressed:

(GP teacher): *"We hope you talk to us… we won't talk to you very much [said with irony]"*

Teachers established a dialogic (i.e., taking place in mutual dialogue), not didactic learning relationship at the outset, accepting a consonant degree of *risk* in teacher-student interaction. The clear intention was to keep everyone engaged, even at the back of the room, or those who may regard GP teaching as irrelevant. This strategy created a safe environment where students spontaneously asked questions and contributed to discussions without fear of humiliation or retribution.

8.6.4 Staying Authentic to Clinical Practice

Teaching moments intertwined with practical tasks based on real-life situations and were accompanied by group-based reflective dialogue in which students were invited to think critically about the social context they were discovering or talking about. Although university based, GP teachers continuously brought discussion back to clinical practice, often sharing authentic anecdotes. The tacit pedagogy embedded in these practices involved an orientation to problem deconstruction and analysis, questioning attitudes and facilitating interactions within a highly responsive and friendly environment.

8.6.5 Risk-Taking Educational Practice

The course was constituted by formal documents such as a study guide. In class, these were used not to reify positivist 'bank deposits' but as a template from which to work creatively. Students were encouraged to see the study guide as a platform from which to launch their clinical experience, rather than a reductive list.

Most GP teachers included storytelling in their sessions, offering narratives that were tangential to the main discussion and using these to respond to students. Educational practices were persistently dynamic, not static. Students were often given opportunities to ask questions, explore aspects interesting to them, and to share cases from their clinical practice. In this way, students informally *directed* content, a pedagogical choice predicated on teachers with the ability and disposition to manage educational risk.

8.6.6 Pedagogy as Activism

The course was constructed around transformative practices directed towards socio-political change:

1. Fostering learners' attitude to be future *active and activist* members of the medical profession.

2. Reforming how medical education is taught and assessed within—and outwith—the medical school.

The *ethos* of the GP course was to familiarise students with the discipline of General Practice. Students were introduced to the distinguishing character of GP and its underpinning philosophy. Stated in the study guide was the central aim not of influencing students to become GPs, but to foster understanding of the differences in primary and secondary care. Teachers implicitly understood that the information they shared was not the only knowledge with value. The pedagogy embedded in this course constituted a form of counter-hegemonic practice, resisting tick-box competencies. This was reflected in both formative and summative assessments. Formative case-based discussions happened throughout teaching. Summative assessment (mandated by the medical school) consisted of positive engagement with a logbook containing workplace-based assessments, and formal case-based discussion facilitated by a GP tutor. We see this choice of assessment as an embodiment of the teachers' intrinsically activist ethos, which again manifests a different philosophical underpinning than the more popular CBME approach.

8.6.7 Knowledge and Power

Hegemony is constituted in the realm of knowledge: a set of formed ideas can either legitimise or question social structures. How knowledge was *enacted* within the GP course showed how students developed the range of 'possibilities for action' (Foucault 2003) from which they drew agency to take constructive action in the world. We identified 5 ways in which knowledge has been enacted in educational practice: as generative, shared, interactive, co-constructed, and goal oriented.

8.6.8 Knowledge as Generative

New ideas were dynamically integrated with existing ones, thus generating new knowledge. An early group task was a perfect example of this: students were asked to think of words or phrases to describe general practice, deciding on the top 3 positive and the top 3 negative words or phrases. During the general discussion, teachers expanded on all these words and phrases with the students, providing examples from their clinical practice, and inviting students to critically examine stereotypes and assumptions:

(GP teacher): "*Who suggested time-wasters?"*
(Medical student): *"In the most diplomatic way possible… Many patients come and some don't really have an appropriate reason for an appointment"*

(GP teacher): *"Ok that's brilliant… The words appropriateness and time wasters stuck with me… I think there's no such thing as appropriateness in a consultation… you may perceive it differently but from a patient's perspective it is not the case, it is never a waste of time" […] "There is always an opportunity there for patient advocacy… which is about wellness… connecting the patient to that wellness"*

So, in this instance (similar practices happened throughout), the teacher used students' pre-existing, uncritical knowledge to generate a new more critical understanding. Students were given the opportunity and the means to generate meaning through creative integration of new ideas with their existing knowledge and experience.

8.6.9 Knowledge as Shared

Personal experience was exchanged among students and teachers in a process of creating (co-constructing) shared new knowledge. Both students and teachers shared their ideas about GP. Often, lectures were designed to be discursive[1]: in one example, two lecturers performed as a dialectic whole, conducting conversational exchanges of experiences and ideas. Here, elements of GP were identified, conceptualised, problematised, deconstructed and given meaning, creating a new, more sophisticated, idea of GP which was then shared by the group. Students and teachers both experienced a dialectic between *spontaneity* (unexamined knowledge) and *conscious direction.* Through holding spaces for critical tension between "old" and "new" ideas, new knowledge was generated and became mutual.

These pedagogical choices required a moral commitment to caring about the 'other'. Trust is essential to grant others custody of one's own knowledge because the other is then empowered as trustee of knowledge. This aspect of critical pedagogy requires a strong sense of safety in the classroom and an ethos of mutual reciprocity.

8.6.10 Knowledge as Interactive

We have seen that this GP curriculum was dialogic and closely aligned with clinical practice. Teachers actively engaged students by involving them in practical group tasks in which not only students discussed real-life case scenarios, but also used tools, such as guidelines or prescriptions, that were real-life artefacts of clinical practice. Teaching did not stand alone, but interacted with reality, objects, and contexts of authentic clinical practice.

[1] We use the term "discursive" here to signify a reflective practice through language use.

In one instance, a prescribing group task brought the discussion towards practical and socio-economic issues. Here, they discuss the rationale for prescribing paracetamol. In the area of the UK concerned, there are no prescription charges, making this free to patients.

(GP teacher): *"How much does a prescription cost to the NHS...£0 for children, £8 for adults, but about £20 in total, GP time etc.…"*
(Student): *"We thought that maybe the family can't afford paracetamol"*
(GP teacher): *"This is important, paracetamol is generic and very cheap. So, it all depends...think of the person in front of you… we don't treat conditions but the person with a condition"*

Here, the GP teacher directed students in a reflective, critical dialogue connecting clinical practice with practical social context. In this sense knowledge was enacted as interactive, and as existing in its dynamic interactions with reality.

8.6.11 Knowledge as Co-constructed

Unlike traditional banking models, students' answers or solutions never marked the end of a task. These were always followed by extensive discussion in which teachers made explicit links with the clinical world and social contexts, often illustrated by anecdotes. Knowledge was expanded and treated critically through interpersonal discursive dynamics. The following comment was made in relation to a complex discussion of how core ethical principles should be enacted:

(GP teacher): *"There's no answer there, we are just trying to highlight the complexities…"*

Throughout the course, students' responses were deconstructed, problematised and reconstructed to collaboratively find alternative possibilities, envisaging alternative courses of action and possible consequences. In this sense, knowledge was not considered *objective*, as something positivist merely transmitted to students, but as something that is *co-constructed* through the discursive dynamics among students and teachers. Didactic, lecture-style moments were minimised, and always used as occasions to provide extra context to the discussions.

8.6.12 Knowledge as Goal-Oriented

In this demonstration of critical pedagogy, knowledge acquisition was not an objective in its own right, but a means to addressing a wider, political goal. Hence, it has a particular direction: in the ethics discussion mentioned above, placing quite lofty and disembodied ethical principles within on-the-ground contexts helped students towards deeper understanding through *feeling and passion.* It is in this way that they

can contribute to social change and justice. The epistemological ramifications of this idea (understanding through feeling and passion) for educators is that knowledge is an engaged scholarship in the service of humanity (Brookfield and Holst 2010).

8.6.13 A Coherent Critical Pedagogy

We have shown how knowledge was enacted as a dialogic social entity. GP teachers fostered students' development through educational interventions based on their potential and current knowledge. Paraphrasing Gramsci, learning happened through students' spontaneous and independent effort, with teachers functioning primarily as overseers and friendly guides. They provided scaffolding by giving students the right amount of assistance at the right time. Knowledge was enacted as a co-constructed entity; teachers often stressed, directly or indirectly, that they did not necessarily know more than students. Rather, they valued students' knowledge as an asset for inter-personal growth, both in the educational and in the clinical environment.

8.7 Developing a Critical Pedagogy

Perhaps the most important aspect of the case study above is one which we deliberately withheld: that is, most of the GP teachers mentioned had had no formal knowledge of Freire and Gramsci a priori. In other words, it is possible to be innately critically conscious without an academic awareness of the theoretical concepts. This offers an essential opening for agency. For example, as a GP, Dr Johnston has found that her instinctive orientation towards educational dialogue comes from her patient interactions, and her commitment to criticality grew from a need to enact social justice within the practice of medicine. For those at the beginning of developing a critical pedagogy, we suggest that reflexivity is the most important place to start.[2]

We have suggested several curricular choices and pedagogic activities below which may be used as a jumping-off point in creating a problem-posing approach. Educators are cautioned, however, to steer clear of the hegemonic 'tick boxing' characteristic of CBME, which might prevent the development of a critical pedagogy. In terms of evaluation, we suggest that when both teachers and learners start to question the orthodoxy that a benchmark of criticality has been reached.

[2] We offer the following as possible starting points: first, consider long cherished ideas and assumptions, and try to trace their roots; what influences are acting on teachers, and what innate values are they oriented to? What is their purpose in taking part in educational activity? Dialogue with oneself and others is a way of life for critical pedagogy and can be easily introduced through supportive teacher development.

8.7.1 Potential Problem-Posing Interventions

Curricular choices:

- Problem-based learning can become a basis for problem-posing education, either at a curricular or simple group task level.
- Longitudinal integrated clerkships and workplace-based assessments, as conduits which exceed the expectations of CBME, and contest industrialised medical education.
- Workshops supporting staff reflexivity and introducing concepts of critical pedagogy.

Class-based activities:

- Move the furniture if the classroom is set up in a banking orientation.
- Design case-based discussions with dialogic plenary.
- Peer to peer teaching.
- Explore students' and teachers' personal axiologies.
- Contest the clinical gaze/ doctor as technician.
- Include authentic stakeholder narratives and phenomenological work.
- Use 'Theatre of the Oppressed': creative interactions which involve students as both players and interacting audience, and which are structured to highlight oppression and encourage criticality (de Carvalho Filho et al. 2020).[3]

8.8 Limitations and Future Directions

As with any theoretical perspective, there are potential boundaries and limitations in working with critical pedagogy. We outline here three of the most significant for us:

- Critical pedagogy represents a highly philosophical position, with Freire's key texts written in a challenging dialectic form (based on new insights gained from juxtaposing argument and counter-argumentation in) translated from the original Portuguese. These aspects make it much less accessible to those without a social science background unless facilitation and training are provided. This is one of many instances where the agency of students and staff may be limited by structural contexts.
- There is a theoretical contradiction between the grand theory of Freire's Marxist roots and critical, situated and highly constructionist practice. This is important because any counter-hegemonic movement may eventually become inflexible and hegemonic in itself. To satisfy the needs of the grand project of Marxism, critical pedagogy would necessarily lose much of its power. This contradiction can, in our

[3] Drawing strongly on Freire, the concept is that the audience take part in the artistic work as 'spect-actors', creating an unusual dialogue which both analyses and challenges inequalities. See Boal (1985) for more.

opinion, be resolved at an individual and community, rather than grand structural level.

- Lastly, Freire's mission was to liberate the oppressed, but the proletariat he refers to are presented somewhat homogeneously, with little regard to separate marginalised groups. To explore the experiences and needs of particular groups, we direct readers to bell hooks' more recent extension of Freire's work, *Teaching to Transgress* (hooks 1994).

8.9 Positionality

We are passionate advocates of critical pedagogy throughout all aspects of medical education. We are all critical, constructionist medical educators with different backgrounds. Dr Johnston and Professor Hart are clinical academics and practising GPs in a deprived part of Belfast, NI, still a divided post-conflict city where critical pedagogy is highly relevant. AM is an educationalist and psychotherapist from a social science background, who is originally from the same place as Gramsci (Sardinia) and has lived and worked in Scotland, England, and Northern Ireland. Our perspective is an emic one. Both Dr Johnston and Professor Hart teach on the course used for the case study.

8.10 Conclusion

In this chapter, we have critically deconstructed neoliberal medical education, which continues to promote the efficiency of banking models at the cost of students' 'ontological vocation' to become fully human. We have presented key aspects of Freire's theory and given an example of how critically conscious principles may be translated practically into action. We advocate strongly for education as a practice of freedom and for the development of critical consciousness as an essential tool with which to address social inequalities in healthcare. Below we offer some useful practice points for educators getting started with their own critical pedagogy (Table 8.1).

Table 8.1 Practice points

1	Encourage reflexivity amongst students and staff
2	Always pay attention to social and political contexts
3	Engage students in friendly dialogue to flatten hierarchies
4	Use narratives (stories) in teaching
5	Move the furniture to facilitate dialogic learning

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Chapter 9
The Philosophy of Social Justice: Lessons for Achieving Progress in Health Professions Education Through Meaningful Inclusion

Angelique N. Dueñas, Marina Politis, and Adam Danquah

9.1 Introduction: What is Social Justice, and Why Does It Matter?

> *… Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution…*
>
> Rudolf Virchow (1821–1902)

While often regarded as the purview of politics, ethics, and law, social justice and its principles are an equally important venture in health professions education (HPE). Ensuring that individuals are empowered to have fair access to healthcare, education, and knowledge should be a fundamental value held by the healthcare community. Indeed, in recent years, there has been an increase in medical organisations directly addressing social justice (Alberti et al. 2018; Kuper et al. 2017; Woollard and Boelen 2012).

Social justice, both as an action and as a guiding moral philosophy or belief, can be a complex topic for those from traditionally scientific disciplines to engage in (Rawls 1971). The word 'justice' alone is a complex notion; while often aligned with a sense of what is morally "right", justice can mean different things, depending on context and

A. N. Dueñas (✉)
Department of Medical Education, Northwestern University Feinberg School of Medicine, Chicago, IL, USA
e-mail: angelique.duenas@northwestern.edu

Health Professions Education Unit, Hull York Medical School, University of York, York, UK

M. Politis
School of Medicine, Dentistry and Nursing, University of Glasgow, Glasgow, UK
e-mail: 2364733p@student.gla.ac.uk

A. Danquah
Faculty of Biology, Medicine and Health, University of Manchester, Manchester, UK
e-mail: adam.danquah@manchester.ac.uk

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philosophical viewpoints (Lambert 2018). As such, it is important here, at the onset of this chapter, to provide our definition of social justice. Social justice is the view that all individuals deserve equal economic, political, and social opportunities and rights. Social justice demands that society and social institutions ascribe to this moral imperative. No matter who you are or your work, we take the position in this chapter that social justice should be an important goal for all practitioners and educators, and one that all feel comfortable engaging with. Medicine and health professions do not operate in a void, as some 'island' of educational pursuits (Woollard and Boelen 2012) but are a key facet of society.

First, consider the patients that HPE ultimately serves. Concerning health disparities continue to exist in patient populations, rooted in social justice issues such as lack of access to quality care, and misalignment of cultural competencies. Students, too, are affected, with social inequalities affecting access to, and attainment in, higher education (Cleland and Palma 2018). Similarly, educators will likely face social justice challenges in their personal and professional lives. This includes 'glass ceilings' and 'sticky floors' that may be encountered in professional advancement (Finn et al. 2021) and the navigation of 'professionalism' that challenges intersection of identities (Crampton and Afzali 2021). It is also important to note the inherent injustice within educational and healthcare systems (Bate 2000), including hierarchies and the challenges some staff may face compared to others (e.g.—the maintenance staff of a medical building, compared to the dean). Finally, social justice encompasses topics such as planetary health and climate justice (See Chapter 16 for a discussion on climate change ethics and education). These challenges highlight the importance of understanding social justice in medical and health professions education. As such, we make the argument that every individual associated with HPE should be equipped to tackle the 'basics' of social justice.

9.2 Structure and Reflexive Notes

While an entire book could be used to examine the intersection of social justice and health professions education—and, indeed, many do exist (Singer and Allen 2017; Bleakley 2020)—this chapter offers a practical approach to recognizing social justice issues in HPE work. With three 'case studies' we will show how social justice can play out in 'real life'. These are subsequently examined with philosophical 'lenses', to show the illuminated power of theories of social justice in HPE. These theories of social justice are selected and applied to show how thinking philosophically in this arena can strengthen our understanding and action in everyday encounters with injustice.

In the realm of social justice, where recognition of privilege is a key element, reflexivity is particularly important (Teo et al. 2014). Our worldviews, identities, and affiliations shape the way we engage and discuss topics. Indeed, this is seen already; social justice is regarded as important in HPE because we (the authors) all believe it to be. But beyond this basic agreement, our lived experiences differ, thus shaping

our contributions and social justice focus. In particular, as a reader, you may have already noted references geared toward medical education, being extrapolated to a more general HPE focus. This reflects our area of expertise and affiliations, but it would be remiss to not recognise the complexities of interprofessional practice and education (Flood et al. 2019), and biases in perspectives we hold. We encourage readers, too, to engage in honest reflections of privilege and power, and reflect on how such philosophies may be applied in your own work.

9.3 Social Justice in Anti-racist Practice: Raimond Gaita's Common Humanity as a Basis for Real World Equity and Compassionate Justice

It is a truism that health professionals' core motivation is to save, prolong, and enhance life. But, all lives are not equal in the healthcare system (Gill and Kalra 2020). As well as disparities laid bare by the Coronavirus (COVID-19) pandemic, we must confront disproportionate maternal mortality rates for Black women compared to white women (Knight et al. 2018), disproportionate infant mortality for Black babies compared to white babies in the care of white doctors (Greenwood et al. 2020), the attainment gap for Black medical students and Royal College trainees (overseas and UK born) (Shah and Ahluwalia 2019) and Black underrepresentation in senior leadership in the UK National Health Service (NHS) (Kalra et al. 2009). These disparities have been attributed to epidemiology, lifestyle, culture, etc., but what place does our culpability have in sustaining and reproducing a system that does not protect Black lives as it does white? What role does structural racism play? Case Study 1 presents one way in which racial disparities might be encountered by healthcare professionals.

Case Study 1: Encountering Racial Disparities

As a busy clinician, editorials are a quick way for you to stay up to date with the literature. You come across a recent piece from Gill and Kalra (2020) in the British Journal of General Practice (BJGP) and are struck by their observation that "all lives are not equal". They go on to summarise findings related to COVID-19; that is, that Black and other minoritised ethnic communities have been disproportionately affected by the pandemic, and that the more than 60% of health workers who have died have been from these backgrounds.

You are shocked and heartbroken about the loss of life in the health professions community, and that the bulk of this burden is borne by people from certain ethnic groups. You are, at the same time, at a loss as to what you can "do" about this information. Yes, you agree, "health inequalities still abound and need addressing", but you are short on time, have full clinics, and your

other educational/professional development work takes up much of any spare time you do get. By the time you get to Gill and Valra's assertion that "in the caring professions, it is often too easy to overlook our culpability in sustaining and reproducing racism," it all feels like too much.

9.3.1 The 'Issue'/Injustice

Close to twenty years ago, de Wildt et al. (2003), in another BJGP editorial, said it was time for the profession to 'grasp the nettle' of racism in response to the Coker (2001) report on racism in the NHS, and the seminal Macpherson report in 1999, which highlighted that institutional racism played a significant role in the police force's mishandling of the investigation into the racially-motivated murder of Stephen Lawrence (Macpherson 1999). These detail the impact of pervasive, and yet subtle, forms of racism that healthcare and health education still struggle to address sufficiently (Wyatt et al. 2021a, 2021b; Crampton and Afzali 2021; Wyatt and Rockich-Winston 2021; Zaidi et al. 2021). Or, should we say, that those within medicine struggle to sufficiently address. The shift from the individual to the structural, systemic, or institutional is often characterised by a sleight of hand, whereby we are merged into an impersonal system of processes and procedures that institute prejudice. One consequence is our—as individuals—disavowal of what is essentially *enacted between ourselves*, and so *responsibility* for the consequent state of affairs.

Further, issues of population-level disparities in health outcomes and structural and systemic racism are broad and sometimes alienating. There is a disturbing truth in the quotation attributed to Stalin, "one death is a tragedy, a million deaths a statistic". Racism is a process founded on stereotypes, "which often make others only partially visible to our moral faculties" (Gaita 2000, 282). It is difficult enough to empathise with numbers, but is this capacity, in medicine as in life, already compromised by a lack of full human regard for the racial other?

Our understanding of racial dynamics has developed considerably in recent years, with various disciplines elucidating how we treat people of a different colour as somehow lesser, and the purposes this serves. Critical Race Theory (CRT) is the most prominent such approach at present (Paradis et al. 2020). CRT's proponents seek to show how the ascendant position of white people is maintained through policy and practice that are legitimised as neutral, but which, on interrogation, are revealed as racist and harmful to Black people. Although separate, contributions to psychology and psychotherapy literature can be said to elucidate how seemingly innocuous, everyday interracial interactions disadvantage Black people (Fakhry Davids 2011), and how this power dynamic is embedded in the psyche and society, even if such a clean break between these domains can only ever be illusory (Dalal 2013).

Taken together, CRT and the psychological approaches outlined suggest addressing racism in any real way requires interrogation of both our systems, and ourselves. But who are *we* here? And who are *you*? Before considering a philosophical approach that attempts to frame social injustices like that in Case Study 1, it is important to take stock of our own experiences. We (the authors) have found that the medical education literature often seems to assume a white, male, cisgender, heteronormative readership (Volpe e al. 2019). One of the authors must own up to assuming this themselves—and perhaps their own socialisation—with the first iteration of Case Study 1 in a draft of this chapter depicting a white GP within a white community at a loss at the loss of so many Black lives. 'Well meaning', perhaps, but what then about the perspectives, voices, and agency of those lives? (cf. Spivak 1988). Some of us are living this, while some of us read it on the page. We must work hard not to do two things, that is: (1) reinforce the very marginalisation we decry with the all too easy assumption of change and agency being for the white actor (even as we acknowledge the disproportionate burden on Black shoulders), and (2) fall prey to the dichotomising processes of racial dynamics, whereby we do cleave a world full of colour into Black and white.

9.3.2 The Philosophy: A Common Humanity (Gaita)

In his book *A Common Humanity,* the moral philosopher Raimond Gaita sets out his rich perspectives on the spectrum of human experiences (Gaita 2013). His thinking (and feeling) about social justice offers a powerful perspective on making those people on the page 'fully our equals' and, with that, real movement towards them. Gaita argues that our characteristic embodiment and ways of living, as humans, condition the concepts with which we think. We cannot stand apart from life and philosophise, but are rather always inside our lives and bodies, having to "think in the midst of things" (14; See Chapter 12 on Ontology for further details on being-in-the-world and embodiment). Going further, Gaita (ibid) argues that the self is morally constituted:

> We cannot radically rescind from the ethical constitution of our inner lives without becoming unintelligible to ourselves. (53)

This morality, delimited by our bodies and the immediacy of life and relationship would appear to have much utility for healthcare and health education. It chimes with Enid Balint's observation that "at the centre of medicine there is always a human relationship between a patient and a doctor" (Balint 1993, 11).

Gaita claims that our ethics depend on a responsiveness towards a fully constituted other, who is able to feel as much as we do and whose life is able to mean as much to them as ours does to us. Gaita quotes the English philosopher Winch thus:

> Treating a person justly involves treating with seriousness his own conception of himself, his own commitments and cares, his own understanding of his situation and of what the situation demands of him. (59)

Racism, according to Gaita, involves the denial of this attribution of a common humanity to the racialised other.

Gaita observes that the anti-racism movement, like feminism (See Chapter 10 for an in-depth discussion of feminism), expresses a concern for equality which goes beyond equality of opportunity and access to goods. According to Gaita, this is social justice due to the insistence that state and civic institutions reveal rather than obscure the full humanity of our fellow citizens. In doing so, we are, according to Gaita, enabled to respond to this full humanity, wherein compassion for those mistreated or afflicted can really be found. Relatedly, consider some of the bases, past and present, for health inequalities associated with racialised communities, which include colonialism, historical abuses (Tuskegee, Sims, and Lacks), and ongoing racism (FitzPatrick et al. 2021). Similar to the question facing former colonial powers, are we in healthcare obliged to examine our consciences, even for past injustices?

Gaita argues that, in order to have true as opposed to empty pride in a country, one must be able to feel shame for what has come before. There is much to be proud of in medicine, but Gaita might counsel that realistic pride comes only after honesty or acknowledgment (See Chapter 5 for further exploration of the concept of acknowledgment) that not everyone is part of the constituency to benefit, and that advances have come at the unacknowledged expense of these same groups. We should feel ashamed about this fact.

Finally, Gaita's is an ethics you can bring your feelings to. He recognises, along with psychotherapists, that feeling is a species of thinking: "A dispassionate judgement is not one which is uninformed by feeling, but one which is undistorted by feeling" (89). Gaita's moral philosophy navigates the dilemma of a rationalism that stands apart from lived reality and an emotionalism that is slave to the dictates of the heart.

9.3.3 Case Study 1, Revisited

Gaita's common humanity may require a re-examination of the GP's responses to the loss of lives. Being 'heartbroken' might signal a sadness borne of an empathy that grants their colleagues full human status. It might, however, stem from a more sentimental feeling that keeps these 'unfortunates' at arm's length.

We are not meaning to be judgemental (healthcare practitioners and trainees experience enough self-attack, e.g., Sampath et al. 2019). Motivations and feelings are nearly always mixed, but if the application of moral philosophy is to mean more than wordier rationalisations for our actions (or inaction), then we have to be prepared to think these things through for ourselves and work out whether we are really moved. It may be in doing so that we are moved towards addressing 'the causes of the causes' of diseases to others (Fitzpatrick et al. 2021).

Psychological theories suggest that racism thrives on unfamiliarity, which creates the vacuum of relating necessary for the unimpeded development of stereotypes. A lesson from a common humanity is that we recognise our being *in media res* (in

midst of things), and attempt to connect with people from different communities, rather than try to fix them from afar.

But what about the implications of Gaita's common humanity for those living, rather than reading, about such losses? One unspoken assumption might be that white people need to extend this full recognition of personhood to people from Black and other minoritised ethnicities. In this case, would it be safe to assume that such compassion already flows the other way? If a common humanity means anything, then it means we must be subject to the same human strengths and weaknesses, so, no. Gaita suggests that a concern for justice in a community should be a concern that institutions enable and encourage us always to see. In medicine, we must look unflinchingly at the damage wrought by differences in power, and what powerful groups do to retain it. The idealised doctor-patient (or doctor-doctor; doctors are not equal) relationship is inflected with power differentials that must be seen in order for us to address them.

How else can this theory be applied to action? The responsiveness necessary to Gaita's moral philosophy may require practitioners and students to witness and experience the lives of those with which they are unfamiliar. Fitzpatrick et al. (2021) discuss the importance of such 'experiential learning' to tackle health inequalities. This should be the case for our colleagues as much as for our patients; Case Study 1 foregrounds disproportionate loss of healthcare practitioners from Black and minoritised ethnic backgrounds demonstrating that all healthcare practitioners are not equal. Psychological approaches suggest we are motivated to keep those we see as different as strangers even in their midst. In this vein, it has always interested us that the UK healthcare system has been so prepared to depend on the Global South's medical and healthcare workforce (depleting already tenuous healthcare systems in the process), but, other than what can be validated through Royal College examination, so unwilling to accept the Indigenous approaches to healing these individuals bring with them. Perhaps this chapter itself, with its focus on philosophy rooted in the Western intellectual tradition, cannot escape this charge of 'epistemological terra nullius'[1] (Dorries and Ruddick 2018). Aside from one's approach to reading philosophy, we have to work harder to embrace all that colleagues bring, for the benefit of their wellbeing, and even patient care.

Engaging with others on matters of social justice is the basis for collective action—a practical application of holism (see Chapter 14 for a philosophy of social science perspective on holism)—which can be seen in such efforts as the London Aces Hub Racial Justice Workgroup, which has been founded to shed light on the impact of racial trauma and facilitate collective action to tackle these harms for individuals and the community (London Aces Hub Racial Justice Workgroup 2020).

[1] Where Indigenous epistemologies and worldviews are not viewed as valid in their own right, but rather read only for similarities to Western modes of thought (e.g., metaphorical interpretation)—if not dismissed or derogated—so that space once occupied by Indigenous thought is occupied by Western scholars.

Engaging with others, especially groups, is also another way to scaffold the psychologically hard work in trying to see and bear what is happening in the world—think back to our GP in Case Study 1 who feels it all too much—and see our own part in this. Desensitisation is what we often must do in healthcare, an important survival strategy. Or tactic perhaps (none of this has to be conscious), as a strategy to negate or avoid burnout. It is hard to stay in touch, so the wisdom, support, and energy of others is essential: reading groups, reflective practice, narrative supervision, Balint groups, group analysis. In the Western philosophical tradition, we idealise the solitary thinker. Gaita (2013) cautions against this in observing that, though the personal nature of ethical thinking means we must think things through for ourselves, we often learn by being moved by what others say and do. Further, "We learn from what moves us because its epistemic authority is inseparable from the fact it moves us" (279). Of course, being moved does not entail morality. It is the dialogic engagement between ourselves and a fully individualised other that allows us to be critically true to what moves us.

If, according to Gaita's formulation, social justice is about true responsiveness to fully realised others, then we have to embrace a medical curriculum that encourages thinking that goes beyond choosing between evidence-based treatment protocols. According to Fitzpatrick et al. (2021), incorporating medical humanities into curricula would enable further insight into patient experience.

9.4 Beyond the Straight Male Norm: Social Justice for Women/Non-binary People and the LGBTQIA+ Community with Considerations About Androcentrism from Simone de Beauvoir's Theories

We, being men, have our patients, who are women, at our mercy

While, on initial reading, we may condemn this view of medicine from 1867 (King 2002, 396) as one far removed from our 2021 healthcare system, this sentiment continues to permeate healthcare, with women and other gender and sexuality minorities still less listened to within medicine (Zhang et al. 2021).

Healthcare professionals are not exempt from harbouring implicit and explicit biases—the racism which permeates medicine was highlighted in Case Study 1, the damage exerted by medicine's white, cis-heteronormative male model is explored in Case Study 2, whilst biases pertaining to those from widening participation backgrounds will be discussed in Case Study 3. Importantly, identities held by individuals or collectives are often intersectional and, in practice, cannot be considered in isolation; this will be revisited in the conclusion of this chapter.

As noted previously, individuals and institutions should confront the biases they harbour and strive to dismantle these, as well as recognising privileges that they experience. An individual endeavour can involve ensuring correct and appropriate naming

and referring to of peers, colleagues and patients, including the use of pronouns, as exemplified by the addition of pronouns to the popular UK #HelloMyNameIs badge which aims to ensure person-centred communication. Case Study 2 outlines an everyday scenario where appropriate naming and addressing of individuals becomes pertinent.

Case Study 2: Pronouns, Titles, and Names

You are a medical educator attending a virtual panel on communication skills teaching in medical schools. As the chair introduces the panellists, you note that they introduce a female panellist by their first name, but the male panellists by their title. You are not sure whether the chair might simply be more familiar with the female panellist. As you examine the event description, you realise that you had presumed that the panellist, listed as a professor on the programme, to be a man.

You also note that the Chair has included their pronouns in their Zoom name. This confuses you, as you deem their pronouns to be 'obvious'. Later on in the meeting, someone suggests whether pronouns might warrant inclusion in the proforma for taking a history that is taught to students, in order to normalise this question.

As you further discuss history-taking, an audience member mentions that many students have raised that questions at times can be heteronormative—defaulting to asking about an opposite-gendered wife/husband as opposed to the neutral partner or simply asking about social supports.

9.4.1 The 'Issue'/Injustice

Ensuring the accurate use of pronouns, titles, and names, and not defaulting to cis-heteronormative assumptions is both a matter of respect and accuracy, but also has tangible health implications. Over half of LGBTQIA+ individuals having experienced depression in the last year and one in seven avoiding seeking healthcare for fear of discrimination from staff (Stonewall 2018). 16% of the LGBTQIA+ community have had negative experiences due to their sexual orientation when accessing health services, this statistic is amplified for transgender/non-binary individuals, 38% of whom have had negative experiences accessing healthcare because of their gender identity (ibid). Where trans and nonbinary youth's pronouns are respected by all or most individuals in their lives, suicide rate is reduced by 50% (The Trevor Project 2020). This also impacts staff and students—LGBT+ doctors report increased levels of workplace bullying and harassment (BMA and GLADD 2016). Increasing calls for

action in challenging the heteronormative assumptions within healthcare, however, are being made (Finn et al. 2021).

The inaccurate addressing of individuals is also observed when women (particularly women of colour) are not titled compared to usually straight, white, male colleagues (Files et al. 2017). Not only does this devalue women's (and other groups') expertise but given the intrinsic link between respect and patient safety/outcomes, it would not be unreasonable to suggest that this too may be extrapolated as to how it affects clinical care. The *Civility Saves Lives* campaign reports that when someone is rude to a colleague, there is a 61% reduction in the recipient's cognitive ability, staff are 50% more likely to miss a calculation error and there is a 50% decrease in willingness to help others (O&G Magazine 2018). Evidently, name and naming 'identities' are a concern not only for many members of the LGBTQIA+ community, but also for other traditionally marginalised groups who are more likely to be mistitled.

9.4.2 The Philosophy, Androcentrism (de Beauvoir)

Androcentrism describes a 'male-centred' perspective, where knowledge of health and illness predominantly focuses on men, and results from and perpetuates patriarchal, misogynistic male worldviews (Verdonk et al. 2009). Throughout all strands of society, men are viewed as representative of the human species, whilst women are seen as deviations from this norm (Hibbs 2014). In this vein, Simone de Beauvoir conceptualises "otherness'", positing "he is the Absolute—she is the Other" (De Beauvoir 1949, 37).

De Beauvoir's concept of othering is relevant to the way in which we treat our patients and the 'standard' patient we centre our teaching on. De Beauvoir's philosophy is just one example of 'Norm theory', which deems women as 'deviants' from the 'normal' men (Hibbs 2014). This relates to Foucault's medical gaze, intrinsically linked to the male gaze, which describes how healthcare professionals modify patient experiences to fit a biomedical paradigm, taking a doctor-orientated approach as opposed to one that is patient-orientated and contributing to medicine's abusive power structure and othering (Misselbrook 2013).

Beauvoir's concept of 'Otherness' takes its basis from Hegel's master–slave dialectic, her "subject" and "other" preceded by Hegel's "master" and "slave". This is relevant to the historical and present-day paternalism permeating medicine's culture. Examples include how, despite Sims' inhumane treatment of enslaved women in the nineteenth century, he is still lauded as the father of gynaecology. Indeed, we continue to refer to the Sims' speculum. Similarly, many medical eponyms refer to Nazis, who committed atrocious crimes against humanity.

In *The Second Sex*, de Beauvoir challenges Plato's postulating that sex is an accidental quality, that women and men are equally qualified to become members

of the guardian class, provided that women train and live 'like men' (De Beauvoir 1949; see Chapter 4 for discussion of de Beauvoir's other major work). De Beauvoir brings to the fore how masculine ideology exploits sex differences to create systems of inequality—this is seen in healthcare, where women's symptoms are often written off as psychological, delaying treatment and worsening outcomes (Maserejian et al. 2009). This can be extrapolated to the health inequalities faced by the LGBTQIA+ community.

De Beauvoir also states that where arguments for equality erase sexual differences, this is counterintuitive, once again establishing the male subject as the absolute, the norm. De Beauvoir's argument for equality insists that equality is not a synonym for sameness and argues against a version of 'equality' where only men, or those who emulate them, succeed. Women, too, must acknowledge sexism they may harbour.

De Beauvoir's proclamation that, "One is not born, but rather becomes, a women" (De Beauvoir 1973, 301) alerts us to the sex-gender distinction. It would be reasonable to expect healthcare professionals to understand the differences between these terms—gender a social construct used to refer to the socio-cultural differences between individuals, and 'sex' a distinct concept, used to refer to biological differences between individuals. These nouns, however, continue to be used inappropriately and interchanged, highlighting medicine's blindness to the social aspect of gender (Bergoffen and Burke 2020).

9.4.3 Case Study 2, Revisited

Reflecting on de Beauvoir's philosophy, we revisit the scenario outlined in Case Study 2 whilst acknowledging the assumptions and stereotypes we inevitably hold. We must consider how we may manifest a medical or male gaze. Case Study 2 foregrounds the implicit gendered attitudes or stereotypes all of us may perpetuate. Despite increasing diversity in patient populations, healthcare professionals do not always represent this diversity, their unintentional cognitive biases perpetuating health inequities (Marcelin et al. 2019). Indeed, a recent systematic review revealed a significant positive relationship between level of implicit bias and lower quality of care (FitzGerald and Hurst 2017).

De Beauvoir's 'norm theory' may also require a re-examination of the attendee's response to the use of pronouns and titles. Norm theory may explain our defaulting to the use of cis-hetero men—whether in the use of antiquated terms such as 'chairman', which should have no place in institutions or committees, or in assuming professors to be men. This also extends to defaulting to men within teaching, e.g., encouraging peer examination on male students, or the over-representation of men in anatomical textbooks (Parker et al. 2017).

9.5 Social Justice in Widening Participation and Access: The Capability Approach to Rethink Outreach

Finally, we turn to social injustice less attributed to specific identities, as explored within Case Study 1 and 2, and more focused on opportunity, particularly *educational opportunity*. Around the world, there is serious unequal representation in the backgrounds and identities of individuals who are healthcare students and practitioners, particularly in historically elite fields, such as medical education (Garrud and Owen 2018). Such inequity and underrepresentation is seen across many identity demographics, such as race and ethnicity (Morrison and Grbic 2015), indigenous groups (Razack et al. 2012), and rurally-located individuals (Dowell et al. 2015). In the UK, underrepresentation persists in the form of socioeconomic inequity, and as such, this is often the target of widening participation activities.

Widening participation (WP) and widening access (WA) are terms used in the UK, and some other countries, to describe the policies and practices designed to address these inequities in access to higher education (Dueñas et al. 2021; Nicholson and Cleland 2015). It aligns with diversity-oriented work. While frequently used interchangeably, there are subtle differences between WP and WA, although these definitions are debated.[2]

Case Study 3 presents a scenario for reflection, with perspectives from the planning side of WP activities, specifically an outreach programme, highlighting differences in perspectives in this field.

Case Study 3: Planning Widening Participation Activities

You are a state-school teacher that sits on a board of organisers for a national outreach programme, aimed at diversifying and widening participation in medical education. In a recent Zoom meeting, one of the leaders for this programme started a lengthy discussion about how students from state schools will be so "behind" in academic content. The leader is suggesting re-structuring the entirety of the outreach programme to focus on more intensive biology, chemistry, and maths to try and support students in being academically competitive medical school applicants. Something about this conversation makes you uncomfortable, but you are not at the medical school, so feel you may not have enough insights to speak up. However, you have had many discussions with students at your school about how the COVID-19 pandemic has solidified their commitment to studying medicine, after seeing their families and communities

[2] The author here ascribes to specific definitions of WP and WA. WP are policies and programmes largely aimed at supporting underrepresented individuals in 'aspiring' to pursue higher education, including expanding recruitment and application (i.e.,– educational outreach). WA is more focused on the system of higher education, enacting policy and programmes that aim to create a 'fairer' higher education selection process, that will help ensure underrepresented individuals have better chances of being admitted (i.e.,—contextual admissions).

suffer both economically and in loss of life. As a teacher, you have been really impressed by these insights. Further, you are concerned that so much focus on sciences, and only sciences, may deter some students who have been told they are "behind" in these subjects, from applying to medicine.

9.5.1 The 'Issue'/Injustice

There are numerous discourses or arguments in favour of WP (as well as some against), and, as a reader, you may be reflecting on yours after reading Case Study 3, noticing differences in perspectives. As in other sections, it would be remiss to not acknowledge our views as the authors of this chapter. Here, the position is that WP (and general diversification) in the field is paramount to its success. WP offers opportunity for educational enrichment, potential for utilitarian healthcare issues,[3] and is the "right" thing to do in terms of social justice and considering the distribution of educational "wealth". This multi-perspective, but favourable view, shades the interpretation and discussion of this work.

Returning to Case Study 3, it would appear that the programme leader might be ascribing to an *educational enrichment* argument for WP, rather than a *multi-perspective* approach. They appear focused on providing educational activities to ensure that WP-background students are not academically "behind," and, therefore, can be more competitive applicants in the medical school. While perhaps well-intentioned, this perspective imagines outreach and WP as part of a *deficit* model. It assumes, based on standards of excellence, particularly in medical education, that students who may have lower academic performance, related to circumstance, are at a deficit to higher performing peers.

This deficit model approach to outreach and WP is problematic for numerous reasons (Greenhalgh et al. 2004). First, it can be harmful to the students that outreach attempts to support. In Case Study 3, the state-school teacher the case follows expresses concerns about this. They worry that this type of discourse and focus will ultimately discourage their students from pursuing medicine. This is a well-founded worry: it has been suggested that deficit models can do more harm than help when it comes to considering WP. Second, it perpetuates the notion that academic performance is the most important factor in HPE. While high academic achievement is an important standard in the field, this perspective is not necessarily true. This point raises philosophical questions in and of itself—what does it mean to demonstrate 'excellence' in healthcare education? Even the most academically 'excellent' student would make a terrible doctor or health care practitioner if they lack empathy,

[3] The 'utilitarian' argument for WP is sometimes conflated with 'social accountability' of medical schools. This posits that institutions should consider patient populations in their recruitment and training of future healthcare providers.

have poor communication skills, or cannot work in an interdisciplinary team. Further, individuals who are from similar backgrounds to patients may be better placed to act with empathy and communicate clearly, having shared life experiences to draw on, already possessing 'excellence' of a different form. This supports arguments for recruiting health care cohorts that are more representative of the population of all patients, rather only those from minority, elite groups.

If WP is to reach its full potential and genuinely support minoritised groups, combatting the deficit model in outreach, and healthcare education, should be a priority in future policy and practice. It has been posited that drawing on philosophy may help us to do this, to better inform practice with theory. As such, this chapter section demonstrates how the theoretical framework and underlying philosophies of the *capability approach* may be a useful theoretical lens to grapple with this issue of deficit models in widening participation (Sandars and Sarojini Hart 2015).

9.5.2 The Philosophy, the Capability Approach (Sen)

At its crux, the capability approach argues that a just and fair society is one that allows for all individuals to have freedom of choice in who they are and what they do (Robeyns and Fibieger Byskov 2020). This framework is built on two philosophical tenets: freedom to attain "well-being" is a moral imperative, and that "well-being" is linked to what an individual can do/be (if they choose). With origins in the fields of human and economic development, the capability approach has also been widely drawn on in considering education, particularly the role of education in social justice work. These links to broader educational action (Hart 2012), the potential for the capability approach has been explored to some extent in HPE (Sandars and Sarojini Hart 2015), particularly for WP-oriented issues.

Specifically drawing largely from Sen's work (Sen 1992, 1993), as well as Hart's that closely aligns with Sen (Hart 2009), engagement with the capability approach requires understanding of its terminology or core concepts. As such, this work presents specific definitions of these key terminologies, with examples that link to healthcare, in Table 9.1. These terms are key in subsequent application of the capability approach to a WP setting, and, as such, the medical education examples are geared toward selection.

These concepts, and how they allow individuals to achieve the functionings that they value most, can be applied to WP, particularly considering the progression of WP-background individuals into and through HPE. Even in the general selection examples in Table 9.1, it is easy to see how these concepts and frameworks apply. WP-background individuals may not have the resources that will make pursuing higher education or HPE seem to be an attainable option, limiting capability sets, even if that individual has the aspiration to pursue a health professions career. Furthermore, conversion factors put in place by medical schools can be a huge barrier to WP-background individuals, including, but not limited to: extremely competitive grade requirements, associated with school type; application fees; or even the cost of

Table 9.1 Capability approach terminology, definitions, and examples

Capability approach terms	Definition	Medical education example
Capability	Opportunity or freedom an individual has to make choices of value in their life	A student may have capability to pursue medical education, if they can use their resources to gain admission, and see this as a worthwhile career path
Functionings	Simply put, the valued 'doings and beings', or what the individual can achieve in their lives	There are many functioning an individual may hold or aspire to in addition to being a doctor, such as being a partner, a parent, a part-time musician, an avid gardener, an amateur chef…
Resources	What an individual has that can be converted into capabilities and functionings; resources can include: *personal* (i.e.- psychological, skills), *social* (i.e.- professional recognition, cultural resources), and *environmental* (i.e.- location, natural resources)	A highly empathetic individual might find this to be a resource in pursuit and consideration of medical education as a career; this individual may have an older sibling who is a doctor, providing a social resource; if this individual lives rurally, this may be a physical resource barrier to medical education
Conversion factors	Factors that are enablers or barriers to a person's freedom and capabilities; conversion factors can include personal attributes, but are most importantly the social structures in place around an individual	Selection, and the given admissions criteria of a medical school, are a key organisational conversion factor that allow or prevent an individual from considering medical school to be a capability
Aspiration set	Constructed by individual reflection, personal goals for well-being and life goals; idealised	Reflecting on their empathetic nature, and hearing from their doctor sibling, the individual in the resources example may aspire to be a doctor, but may also consider nursing as a fulfilling job; their aspiration set may include a multitude of clinical careers
Adaptive preferences	When an individual internalises and accepts conversion factors and resources, influencing capability preferences and choices	An individual who attends a Medical School open day/taster/outreach event may internalise this experience, resulting in medical education being higher in their aspiration set
Capability set (of Potential Functionings)	Collection of capabilities or choices, considering the aspiration set but also realistic / pragmatic, as these consider conversion factors and individual choices	An individual may have aspired to medicine, among other clinical careers, but if they do not meet minimum grade requirements, their capability set cannot include it

(continued)

Table 9.1 (continued)

Capability approach terms	Definition	Medical education example
Achieved functionings	What the individual actually does or who they are; not all potential capabilities are possible, nor all potential functionings achieved	A student, who has the resources, aspirations, and is enabled by conversion factors, can be successfully admitted to medical education, becoming a medical student

education, itself. Additionally, with deficit-model discourse, and similar discourses that posit education as a meritocracy, or that medical education or healthcare education is not attainable, WP-background individuals may be susceptible to negative adaptive preferences. This is alluded to in Case Study 3, with the teacher's concerns that over-emphasising barriers and deficits will deter their students from applying to medicine.

But, with knowledge of these elements, the capability approach can be used as a framework to better understand and support the function of WP and WA. Programmes and policy can be examined, to help identify what conversion factors are key, what resources are most important, and how to yield adaptive preferences for inclusive choices. The capability approach can yield insights for how to use social justice theory in practical ways, to reconsider distributions of resources and be critical of social structures.

9.5.3 Case Study 3, Revisited

Returning to Case Study 3, now with knowledge of the capability approach, we can rethink actions that could have followed this scenario. In the example, it's clear that, from the schoolteacher's experiences, that many of their WP-background students see medical school in their aspirational functioning. But the deficit model of outreach proposed does not necessarily help students achieve this functioning; it highlights shortcomings, instead of emphasising and supporting capability of the individual to achieve this career if they choose. This leads to concerns about adaptive preferences that may limit student's aspiration sets, capability sets, and eventual achieved functioning.

Informed with theory, this schoolteacher might feel more comfortable speaking up, citing work like this, or others, to demonstrate to the organisers the social complexity of the situation. Advocating for students by writing an email or similar letter, citing these philosophical underpinnings, might be another route for the schoolteacher to consider. In either case, using the capability approach can be a helpful philosophical tool to rethink how we go about educational social justice.

9.6 Conclusion

In this chapter, we have cast light on just three types of social injustices that mar HPE. But we have also shown how employing philosophical thinking, and drawing on theory, can aid, not just in understanding these injustices, but in improving on work to mediate them. Table 9.2 reiterates the philosophical lenses we have applied in this chapter, with brief descriptions, for summary.

It is important to note that these are just a mere subset of social justice theories, and that the proposed 'solutions' to tackling social injustices are just one set of possible actions. As such, Table 9.2 also notes some potential criticisms of these theories, for readers to reflect on. Further, our ability to address injustice, and indeed function in

Table 9.2 Social justice philosophies, revisited

Philosophical lens	Brief description	Potential criticisms
Common humanity	Our ethics depend on a responsiveness towards a fully constituted other, who is able to feel as much as we do and whose life is able to mean as much to them as ours does to us. Treating a person justly involves treating with seriousness their cares and conceptions. Racism involves the denial of this attribution of a common humanity to the racialised other. Social justice means that state and civic institutions reveal rather than obscure the full humanity of our fellow citizens, which enables true compassion	Is the approach too much based on Western individualism, with a veneration of the subjective, personal, individual life? In trying to counter over rationalist philosophies, does the approach fall prey to emotionalism?
Androcentrism	Androcentrism describes a 'male-centred' perspective where men are viewed as representative of the human species, whilst women are seen as an 'other'. Beauvoir's argument for equality insists that equality is not a synonym for sameness, and argues against a version of 'equality' where only men or those who emulate them succeed	Can this essentialism reinforce gender norms and binaries by inadvertently creating a dichotomy between 'andro' and 'gyno'? Furthermore, does it neglect the nuance behind different levels of privilege? How do we ensure we account for ethnocentrism and heterocentrism and do not create a universal false male versus female experience
Capability approach	Social justice means that all individuals can achieve personal well-being, by having choice in what they do and who they become	Is the capability approach unnecessarily individualistic? How do we grapple with freedoms/wants that might be viewed as 'bad', that could harm others?

Table 9.3 Practice points

1	When considering the potential use of social justice philosophy in HPE, reflexive thought on power and privilege should be continuous
2	A large part of social justice work requires first fully recognizing injustices, then moving to continuous work in addressing them
3	Social justice work needs to consider all levels of HPE, from the individual to the institutional to the systemic. Different philosophical frameworks may prove more applicable in different settings
4	Philosophy and philosophical thinking can add depth to understanding the many types of injustices that are encountered in HPE every day, but this needs to be translated to action
5	While this chapter focuses on more singular forms of social injustice, intersectionality, and how it may impact and conflate injustices, needs to be considered

educational settings, is highly variable based on context, location, situation, and, as mentioned in the introduction, the privilege and power we hold.

We conclude with the importance of recognising intersectionality (Monrouxe 2015; Eckstrand et al. 2016; See Chapter 9 for further discussion on intersectional approaches), as briefly acknowledged in above sections. The aforementioned case studies focus on singular forms of justice across race, gender, sexuality, and educational access to allow readers to engage with particular aspects of the philosophies presented. 'Real-life', however, is rarely that simple. Each of us hold many, intersectional identities, that inform privilege, and thus power, to enact social justice. For example, an individual who is white, cis-gender, female-identifying, from a low socioeconomic background, may hold certain power in some spheres, and be minoritised in others. Further, this individual might have unique views on whether they consider themselves to be "minoritised" in any given sphere. We are all multidimensional beings, and social justice work should consider this, as those with various minoritised identities can sometimes, inadvertently, be overlooked.

As previously noted, this chapter represents only a limited exploration into the world of social justice and, like much of health professions education, continuous education is critical. True action and allyship relies on all individuals putting in the work to self-educate. We encourage readers to use this chapter as an invitation to engage in further social justice reading and as a possible guide for real action. It is only by way of such continued engagement that justice may be achieved (Table 9.3).

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Chapter 10
The Future of Healthcare is Feminist: Philosophical Feminism in Health Professions Education

Lena Wånggren and Gabrielle Maria Finn

10.1 Introduction

Gender bias in healthcare is rife. In 2020, the United Nations reported that nearly 90% of both men and women across the world's population harbour some form of gender bias against women (UNDP 2020). Within medicine, gender bias is associated with poorer outcomes for women in many domains, including regarding pain management, and diagnostic delays for gynaecological conditions (Perez 2019; Verdonk et al. 2009; Winchester 2021). Gender inequality is an ongoing issue within society and, more specifically, within medicine and health including in medical and health professions education. Global and national policies often fail to consider gender-related health risks for people of all genders (WHO 2019). It is clear we need health systems that consider the intersections of gender with other inequalities, addressing how "gender norms, unequal power relations and discrimination based on sexual and gender orientation impede access to health services" (WHO 2019), including in the delivery of health education.

Philosophical feminism employs philosophical methods to feminist topics and questions, and so holds the potential to illuminate ongoing issues within health professions education, such as gender bias, in new and critical ways. Philosophical feminist inquiry is motivated by desire for social justice and so, through scrutinising

L. Wånggren (✉)
School of Literatures, Languages and Cultures, University of Edinburgh, Edinburgh, UK
e-mail: lena.wanggren@ed.ac.uk

G. M. Finn
Division of Medical Education, School of Medical Sciences, Faculty of Biology, Medicine and Health, The University of Manchester, Manchester, UK
e-mail: gabrielle.finn@manchester.ac.uk

Health Professions Education Unit, Hull York Medical School, University of York, York, UK

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social, cultural, political, and economic phenomena within medical and health professions education using feminist thought, recommendations may be made regarding confronting structural inequalities within healthcare.

This chapter considers philosophical feminism broadly, considering the ways in which gender combines with issues of race, class, disability, sexuality, and gender identity and examining contributions which have been overlooked in reference to the field of health professions education. Intersectionality as a concept and practice is introduced to understand ways in which gendered and related oppressions and privileges combine to create a need for more complex understanding of philosophical feminist inquiry in health professions education, and feminist theories of agency in relation to healthcare are explored. Addressing the structure and dynamics of gender bias within health professions education, the chapter opens new fields of enquiry and ways of working. Finally, we offer practical considerations for those in the sector to consider how philosophical feminism informs their practice.

10.2 Philosophical Feminism: Feminist Thought and Practice

What has been called philosophical feminism, or feminist philosophy, specifically examines the role of gender in traditional philosophical concepts, sexist bias in traditional philosophy, and proposes philosophical feminist theories (Vogler 1995; Alcoff and Kittay 2007; Garry et al. 2017). However, feminist thought is an interdisciplinary subject found across academic disciplines, creative practices, and social movements, from the sciences to the arts.

Feminist theories and practices describe several different interlinked approaches, all emphasising the role of gender and gendered structures in society. Feminist theory is often referred to as an umbrella term (Disch and Hawkesworth 2018; Finn and Brown, In Press). While scholars have emphasised the need to address gender bias from a localised context, taking into account specificities of local structures and cultures (Mohanty 2003), feminist approaches share a focus on interrogating concepts of gender, fighting gender injustice, and analysing the ways in which gender shapes our lives. Feminism is not just interdisciplinary, but practical, aiming to change the way we think and order society: feminism is about *doing* just as it is about thinking; 'deeds not words', as the old Suffragette motto noted. Feminist theorist bell hooks (1984) similarly notes that one cannot simply 'be' a feminist, one has to *do* or advocate feminism. This chapter uses a broad interchanging and interdisciplinary definition of philosophical feminism, feminist thought and practice, as terms signifying the questioning and fight against gendered and intersected oppressive ideologies, practices, and structures.

Feminist thought reaches back millennia, and feminist historiography[1] usually uses the metaphor of 'waves' to describe different trends and shifts in feminist movements throughout the years. Despite being a contested metaphor (van der Tuin 2009; Hemmings 2011; Reger 2017; Grady 2018), it continues to be used both temporally, as pertaining to a specific historical period, and also as demarcating certain broader issues occupying feminists during the associated period. The starting point of the 'First Wave' of feminism is often located either with the publication of UK writer and philosopher Mary Wollstonecraft's (1759–1797) *Vindication of the Rights of Woman* in 1792, or with organised women's movements in the nineteenth century (demonstrated in milestone events such as the 1848 US Seneca Falls Convention and the Conference of Badasht in Persia), following intellectual women's societies that sprung up in the mid-eighteenth century such as the Blue Stockings Society in Britain. Located in the late eighteenth, the nineteenth, and the early twentieth centuries, first-wave feminism took different forms for different women and in different locations but is usually defined as involving the fight for civil rights such as suffrage, marriage and property legal reforms, and women's access to education (including the right to practice as doctors).

Definitions and interpretations of feminist 'waves' differ, however: while Wollstonecraft's *Vindication of the Rights of Woman* is often seen as the mark of the birth of modern feminism, with its call for gender justice and criticising of gender bias, history recalls earlier feminist works such as Christine de Pizan's medieval *The Book of the City of Ladies* (1492) which questions gender bias in literature and history. Further, figures such as Sojourner Truth in 1850 already questioned not only gender, but racist thoughts and practices. Due to a white European and US dominance in feminist historiography, scholars have, until recently, defined the movement as one primarily concerning middle-class or liberal white feminists' concerns (such as the right to own property) in the global North, a perspective which has been proven incomplete by postcolonial and transnational feminists noting concerns not only regarding women's right to education and suffrage, but also labour conditions, the abolition of slavery, anti-colonial struggles, and peace building (see e.g. Jayawardena 1986; Wånggren 2018). Within health professions education, the fight for women's access to higher education is crucial, as early female doctors such as Elizabeth Blackwell, Elizabeth Garrett Anderson, and Sophie Jex-Blake in the nineteenth century fought for women's right to study for and obtain medical degrees. Although women now constitute a huge proportion of health professionals, they remain under-represented in some specialties and leadership roles (Skinner and Bhatti 2019, Gilmartin et al. 2020).

The Second Wave, usually timed as 1949–1990, highlighted issues of equal pay, sexual freedom, representation, reproductive justice; this is when feminism entered knowledge-producing institutions such as universities. Simone de Beauvoir's *The Second Sex* (1949) questioned the notion of gender itself, showing its socially and historically constructed nature: "one is not born but becomes a woman" (283). Martha

[1] Historiography is defined by the Oxford English Dictionary as "the study of the writing of history, and of written histories".

Weinman Lear first officially documented the term 'wave' in a 1968 article, as a historical benchmark to position current 'second wave' feminist struggles against those of earlier generations, although the term had been in use prior to this publication (Chamberlain 2017). These are the years in which feminist activists started engaging most fully with gendered inequalities in health and access to healthcare, highlighting gender bias and the lack of women's perspectives within care, and in which feminists question the perceived objectivity of scientific knowledge—see a fuller examination of this period below.

The Third Wave, from around 1990 onwards—with Judith Butler's groundbreaking book *Gender Trouble* seen as a milestone—involved a questioning of the singularity of woman, and a further questioning of the relation between gender and sex: the multiplicity of women's experiences is highlighted, noting intersectional and transnational perspectives, and interlinking gendered with other related issues. In healthcare professions education this is seen through an increased focus on not only gendered but other intersecting inequalities, across the globe.

There is currently a self-identified Fourth Wave, from the early 2000s, which highlights the use of social media and humour to address everyday sexism, street/workplace harassment, and rape culture (Cochrane 2013; Chamberlain 2017), seen in the growth of grassroots online campaigns for gender-sensitive healthcare—for example for trans persons, and for under-researched conditions such as endometriosis and questions of reproductive health (see e.g. Davey 2020; Cysters 2021; and UK campaigns around Period Poverty).

As a result of feminist and antiracist activism across centuries, especially through the work of Black and anti-imperialist feminists, intersectional theories and practices have gained ground, bringing a valuing and accepting, rather than denying of, what Audre Lorde (1984; see also Hill Collins 2000) terms 'difference':

> Certainly there are very real differences between us of race, age, and sex. But it is not those differences between us that are separating us. It is rather our refusal to recognize those differences, and to examine the distortions which result from our misnaming them and their effects upon human behavior and expectation. (Lorde 1984, 1–2)

Within healthcare professions education, this embracing of intersectional difference means an increased awareness of shifting perspectives of gender, race, class, religion, age, disability, sexuality, and gender identity within pedagogy and practice. Recently, intersectional identities have grown in prominence within the undergraduate curriculum, particularly within basic sciences such as anatomy (Lazarus 2021). Student cohorts are demanding the redefining of anatomical language in order to create safer spaces to acknowledge all genders (Lazarus 2021), racial identities and ethnicities (Finn et al., In Press).

Feminist philosophy broadly means linking theory and practice. In the sciences, we must specifically trouble the assumptions we have about what is considered 'knowledge' by questioning the perceived impartiality of knowledge, and who is in a position to be seen as a knowledge producer. What is crucial is highlighting the validity of subjective experiences, especially of marginalised groups, as central to knowledge production, something which demands reflexivity from those positioned

as 'experts' (Harding 1986; Haraway 1988; Rooney 2017). Feminist perspectives in healthcare professions education thus require a questioning of the kinds of knowledge produced in a healthcare setting, who produces knowledge, how this knowledge is captured, and what kind of power relations govern the roles attributed to patient and health professional. It means centring the feminist notions of reflexivity and positionality as key tools (Erikainen et al. 2021) in designing and delivering programmes. Embedding reflexivity allows for a critical interrogation into power relations and our situated places within them, while feminist notions of positionality means recognising that all knowledge, including scientific knowledge, is "situated, plural and partial", shaped by the knowledge producers' social location—this fact enables us to ask critical questions about who is seen as a knowledge producer (Erikainen et al. 2021, 9). For example, a young male nurse or doctor and a female patient in her 60s may have different knowledges about the experience of menopause; one being clinical 'expert' knowledge, the other being personal and experiential. These differences need to be reckoned with in order to provide a contextualised healthcare understanding the complexity of the situation.

10.3 Key Terms: Gender and Intersectionality

Gender is one of the key terms within feminist thought and practice, used to examine and address gender inequality and bias within patriarchal structures. Joan W. Scott's (1999) definition of gender links the concept with power, and as working on different overlapping levels of society:

> [G]ender is a constitutive element of social relationships based on perceived differences between the sexes, and gender is a primary way of signifying relationships of power. (1067)

Scott (1999) maps out the different levels at which gender operates: *symbolic and representational* (assumptions about gender difference); *normative concepts and statements* (e.g. religious, scientific, and legal doctrines); *social institutions and organisations* (organisational); and as *subjective identity* (how one sees/presents oneself).

Gender is not, however, the only social category intertwined with health. As such, health is more fruitfully understood through the lens of intersectionality, that is to say, alongside other axes of power such as those linked to class, sexuality, race, disability, sexuality, or gender identity. Intersectionality (Crenshaw 1989) is the notion that various social and cultural categories such as gender, race, and class, interact and overlap on multiple levels in the formation of identities and social relations (Cooper 2016). The term started as a main tenet of Black feminism to describe the intersecting oppressions facing Black women and has now gained influence in contemporary feminist activism as well as mainstream policymaking. Feminism, in an intersectional definition, signifies then not only a struggle for gender equality, but "a struggle to end sexist oppression" which harbours in it "a struggle to eradicate the ideology

of domination", realising the "inter-relatedness of sex, race, and class oppression" (hooks 1984, 24–31) alongside other structures of inequality.

10.4 Gender Inequality and Bias in Healthcare and Professions

In every society, what is considered health or illness, and how the health professions deal with these terms, are shaped by social, historical, and economic contexts—contexts that are all gendered. As Angela Davis (1990) declares:

> Politics do not stand in polar opposition to our lives. Whether we desire it or not, they permeate our existence, insinuating themselves into the most private spaces of our lives. (53)

A key tenet of feminism is, thus, the interlinking of individual with structure—the personal is political. Gender, that social categorisation of behaviours and beings, permeates the ways in which health and medicine are structured and how we understand ourselves within it. As part of the 1960s and 1970s women's movements, feminist scholars and women's health activists started addressing issues of gender within medicine and healthcare—often starting with the issue of 'women's health' as a focus and connected to social movements for women's health. Since then, the field has broadened and now encompasses multiple areas including Science and Technology Studies and the Humanities. We have moved from a focus on 'women's health' to gender inequalities in health (Hunt and Annandale 2011; Kuhlmann and Annandale 2012). Feminist critical attention to healthcare has revealed bias and oppression, as well as opened up new perspectives on health, caring, and knowledge. Not only does health science itself contain bias, but also practical understandings of medicine are biased along structures of race, gender, and certain forms of power and knowledge (Wyatt et al. 2020; Zaidi et al. 2021). For example, health professions education remains focussed on the white male as the archetypal representation within textbooks on clinical examination and anatomy (Plataforma SINC 2008; Finn et al. 2022; In Press).

With increased research into both men's and women's health, there is a new appreciation for the complexity of the 'paradoxical gender differences' (Bird and Rieker, 2008, 7) in health that challenges notions of the disadvantage or advantage of one single gender (MacIntyre et al. 1996). Antiracist and intersectional critiques of western clinical medicine have recently been brought into focus (Hankivsky 2012), with new approaches and interdisciplinary pathways to understand intersecting relations within health. While white women's experiences were (and probably still are) for long at the centre of the field of gender and health, there has been a growing body of work by women of colour and their experiences of health; Black feminists in particular have contributed much here, through works such as *The Black Women's Health Book: Speaking for Ourselves* (1990) and *Wings of Gauze: Women of Color and the Experience of Health and Illness* (1993). In recent years, activists such as Neelam

Hera have set up campaigns and networks to raise the voices of marginalised women and trans people within reproductive healthcare (Cysters 2021), or to address racism within healthcare (see Walcott and Linton 2018, for stories of racist mistreatment in mental health care, and a call for changes needed in health professions education). Alongside a continued struggle for gender-sensitive and antiracist training in healthcare, the end of the twentieth century saw more focus being given to the issues facing specifically trans and intersex individuals (for example: the Intersex Society of North America was formed in 1993). However, the health professions curricula have not kept pace—transgender health and largely also intersex healthcare remains undiscussed (Fausto-Sterling 2000b; Finn et al., 2021), while many students in healthcare professions have little understanding of the healthcare lexicon including 'cisgender' (Dubin et al. 2018; Brown et al. 2020). This leads to a healthcare system where patients rarely encounter trans- and intersex-inclusive healthcare (Bornstein 1994; Fausto-Sterling 2000a; Halberstam 2017).

Gender inequalities in health have been a major area of both activism and academic scholarship since the early 1970s. Since then, the search for an explanation for differences in male and female morbidity and mortality, alongside interest in the relationship between variations in women's social circumstances and their health, has been a crucial part of feminist enquiries into health care and professions (Hunt and Annandale 2011):

> Gender is known to be strongly associated with health status and to exert a significant influence upon help-seeking and the delivery of healthcare, but it has been a relatively low policy priority for many governments and also within the health professions until very recently. … [T]he current evidence base is scattered and fragmentary. Attempts to mainstream gender into healthcare often turn out to be simplified reports of sex differences without taking account of the complex life conditions of men and women and the gendered dimensions of the organization and delivery of healthcare. (Kuhlmann and Annandale 2012, 1)

The lack of a gender-sensitive approach in healthcare leads to women being "routinely silenced or erased as actors in the production of health, in both the provision and receipt of healthcare per se as well as in health politics and policy" (Clarke and Olesen 1999, 3). Even in 2018, so significant still are the gender inequities in medicine and healthcare that a lexicon of gender bias terms was published (Choo and DeMayo 2018). One frequently observed gender bias is the maternal wall bias, which pertains to the stereotyping and discrimination encountered by women (Williams 2004). Women are treated differently because they have children, may want children, or even just because they may potentially become mothers. Socialisation into gender roles, and expectations of stereotypical gender expression, has resulted in inflexible, archaic inflexible expectations of men and women. Recently, the maternal wall was documented within health professions education, with undergraduate students describing missed opportunities based upon perceptions of the present or future maternal status (Brown et al. 2020).

Feminist perspectives in health care involve not only a focus on substantive topics within women's health such as breast cancer, violence, or reproductive justice, but also highlighting gendered narratives within medicine, such as the positioning of the white male patient as norm of what is healthy, or the use of sexist language in

medical research and practice. As Longino (1990) shows, assumptions laden with social values affect the description, presentation, and interpretation of data; research on 'sex-differentiated behaviour' involves assumptions not only about gender relations but also about human action and agency. As Emily Martin (1991) has demonstrated, the ways in which we speak about health-related issues are not 'scientifically objective' but rather carry imprints of gendered, racialised, and other contexts; there is specific gender bias in scientific and medical discourse, particularly concerning human reproduction. Martin's *The Woman in the Body* (1987) questions the disparity between biomedical formulations of women's health and women's own experiences of, for example, menstruation, birth, and menopause. Querying the negative perception many have around menstruation, she examines the gendered language and metaphors in which menstruation has been described, in order to understand this negativity. As Martin describes in "The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles" (1991), seemingly 'neutral' scientific explanations such as "the sperm forcefully penetrates the egg" are presented with a sexist bias that places women's part in reproduction as passive. Black feminist and antiimperialist interrogations have furthermore noted racist, colonial and class bias within struggles for reproductive justice (Gould 1984; Kuumba 1999; Silliman et al. 2004).

Adding to Martin's work on gender bias in science and medicine, and on the role of women's own constructions of health outside of biomedical narratives, feminists have criticised the ways in which medical norms are often based on white, middle-class men's bodies, revealing a lack of diversity in health professions research and education (Lorber and Moore 2002). Until recently most health research focused on white male subjects, and less is therefore known about how to prevent and treat many illnesses in women (Bird and Rieker 2008). Because of this, there are still significant gaps in knowledge regarding health differences between the sexes in health (Marcelin et al. 2019). For example, men's and women's cardiovascular disease symptoms differ from each other, but since most research was carried out and information distributed with male patients in mind, women did not benefit equally from this research (Bassuk and Manson 2004). While gender and race usually are considered socially constructed, gender and intersecting biases have also worked to exclude physiological differences or ignored the biopsychosocial effects of sexism and racism (Sullivan 2015).

As feminist theory and methodology demonstrate, the ways in which we speak about health-related issues are not 'scientifically objective' but rather carry imprints of gendered, racialised, and other contexts—there is a significant gender bias in scientific and medical discourse. Understanding and addressing biases is a crucial way to improve health professions education. Introducing structural/unconscious bias or other Equality, Diversity, and Inclusion (EDI) training is a necessity within health professions curricula; without such work, health inequalities and differential treatment will continue. Furthermore, those working within the institutions, for example admissions teams, also need training to ensure diverse and inclusive workforces for the future. Similarly, an awareness of the hidden curriculum is of paramount importance (Hafferty and Franks 1994)—tacit messaging, role modelling and other aspects

impact learners, educators, and patients alike. For example, students may witness tutors (Finn and Hafferty 2020) or near-peers role modelling negative behaviours such as assumptions of cisgender identity or heteronormative patterns when taking a history (Laughey et al. 2018), or microaggressions based on gender or maternal status (Brown et al. 2020).

10.5 Reclaiming Health: Gender and Agency

The issue of patient agency and female agency has been crucial to women's health movements in the 1960s and onward in challenging male patriarchal control over women's health. Feminist theories of agency are thus crucial to considering ways of improving health professions education.

While modern biomedicine often comes to treat the patient as an object, infringing on the patient's agency over their health, this tendency has been critiqued, especially by feminist health activists who highlight the silencing of women's experiences in healthcare. Indeed, biomedical approaches can influence women's perceptions of themselves and their bodies, in ways which 'can ultimately undermine women' (Clarke and Olesen 1999, 33). In particular, reproductive justice has long been a central focus of feminist activism and scholarship (Correa and Petchesky 2003).

Certain groups (women, LGBTQIA+ people, people of color, working-class people) are more likely to be medicalised—treated as medical objects rather than subjects—and in different ways than others (Riska 2003), since aberrations from the white male norm is seen as individual biological problems rather than as affected by social structures. Feminist movements have thus sought to reclaim women's health and to focus on women's own experiences, to regain agency over such debates. In the late 1960s feminists challenged medical and male control over women's health, in movements ranging from local grassroots organisations and self-help groups to feminist health clinics, advocacy organisations, and scholarly research. In 1976 the now classic *Our Bodies, Ourselves* was produced by the Boston Women's Health Collective, one of the first in a wide range of writing through which women developed ways of understanding their own bodies and of challenging sexist bias in the medical profession.

Storytelling, and sharing stories of pain, have been crucial tools for reclaiming agency (Wånggren 2016). Two examples of feminist thinkers doing this are Audre Lorde (1996) and Johanna Hedva (2016, 2017). Lorde in *Cancer Journals* (1980) and *A Burst of Light: Living with Cancer* (1987) and Hedva in their "Sick Woman Theory" and "Letter to a Young Doctor" both address sexist biases in health professions, argue for a reclaiming of patient agency in the name of equality and social justice, and highlight the need for sharing stories of pain in order to heal. Hedva (2017) addresses a young woman studying to become a doctor, who has written to the author for advice:

> One of the problems with healing in this fucked-up world is that it's presumed that you, the doctor, have a set of knowledges that the patient doesn't, so for the patient to get better, to be cured, or to heal, they must submit themselves to Doctor's Orders. … I'm supposed to trust you simply because you are a doctor. To us patients, this dynamic feels like one in which we are helpless because it is. It feels one-sided, dangerously unequal. I have to give my trust to you, but not because you've earned it. It's because you work in the hospital, or the clinic, a place that is a metonym for medical expertise; it's because you speak in the coded language of medicine and wear the white lab coat, a rehearsed performance with its attendant costume. I don't feel like you trust me, because you are treating me, or parts of me, as enemies to be vanquished. … What if, instead, the presumption went both ways—that the patient was *also* a specialist, like you, in possession of a set of knowledges, a vision of a world we'd like to build, that is different from this one, and so by collaborating as equals, utilizing each person's skills, we might together build a world that contains multiple parts, a world that is not only one part—your part?

Writing about her struggle with cancer, Lorde declares that:

> Attending my own health, gaining enough information to help me understand and participate in the decisions made about my body by people who know more medicine than I do, are all crucial strategies in my battle for living. (1996, 321)

In a quest to reclaim agency over one's own body, writers, researchers and activists describe their experiences of pain and struggle: "I had known the pain, and survived it. It only remained for me to give it a voice, to share it for use, that the pain not be wasted" (Lorde, 1996, 9).

In health professions education, learning to centre the patient experience, providing them the right to formulate their own experiences about their bodies and to assert agency over their narrative, is crucial. Health professions education scholars have presented much research looking at contemporaneous examples of gender inequity and the troublesome perpetuation of negative behaviours towards women (Monrouxe, 2015). Examples from the ethical and professionalism dilemmas literature, as well as the popular press, include medical students being coerced into performing intimate examinations on anaesthetised women without consent and obstetric abuse against women (Carson-Stevens et al. 2013; Santhirakumaran et al. 2019; Shaw et al. 2020). Without open discussion with aspiring clinicians, such issues continue to manifest and present professional dilemmas for students who feel conflicted due to perceptions of relative power and hierarchy. Shaw and colleagues (2020) recently discussed concerns with regard to medical students' professionalism development, highlighting the extent to which gender bias is ingrained within medical systems. Their study reports the normalisation of disrespectful and abusive treatment of female patients poses immediate and future consequences to the wellbeing and safety of women.

10.6 Ethics of Care, Vulnerability, and Interdependence

Feminist thought has added much-needed new perspectives within health professions educations, encircling a feminist ethics of care which emphasises interdependency

and vulnerability (Gilligan 1982; Mackenzie et al. 2013; Hauskeller 2020). As Lorde writes in *A Burst of Light*, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (1996, 332). Feminists have taken up this call for (collective) self-care to encompass experiences of living with chronic illness and disability. In a 2016 essay, the aforementioned Hedva proposes their "Sick Woman Theory", in which they propose sick bodies—those who, as Lorde puts it in *A Burst of Light*, were never meant to survive—as the twenty-first century's sites of resistance. In a society where one's health is defined in relation to whether one is able to go to work, Hedva (2016) writes, one of the most anti-capitalist protests is "to care for another and to care for yourself. To take on the historically feminized and therefore invisible practice of nursing, nurturing, caring".

Drawing resources from feminist academic research as well as activist groups, feminist thought and practice allow us to highlight gendered, racialised, classed, and other intersecting dimensions to health, and to centre not only epistemic justice and storytelling, but also empathy and an ethics of care.

Of course, promoting discourse on issues such as vulnerability and interdependency within the educational setting can be difficult and nuanced. Recent literature in the field of medical humanities advocates for the use of the arts and humanities as tools for broaching topics that may be sensitive or nuanced; indeed, much feminist literature and arts explore women's and gendered experiences of health and illness (Wånggren 2016; Foster and Funke 2018; Dudley 2021). Example activities could include: the creation of artworks on what it feels like to experience disease or illness as a woman; authoring love and breakup letters (Laughey et al. 2021) to the patriarchy or marginalisation based upon gender; or writing poetry on intersectionality. Key is the creation of a safer space for discussion.

10.7 Conclusion

Feminist thought and practice help us understand and address existing biases within health professions education, and to articulate new perspectives and practices that will serve us better. Alongside and intertwined with feminist activism, antiracist, LGBTQIA+, and disability activism allow us to counter bias in health professions practice and education. Feminist health and medicine scholars and activists have highlighted the sexist biases in science and medicine, questioned the medicalisation of women's bodies and minds, and highlighted health inequalities among women and other groups. Addressing the ways in which social, cultural, and political factors influence discourses and experiences of health, and understanding the historical roots of gendered inequalities in health, is crucial in improving health professions education (Table 10.1).

Table 10.1 Practice points

1	Embed reflexivity practices within programmes, allowing students and professionals to critically enquire and address their own and the patient's positionality and how this affects knowledge production
2	Include intersectional perspectives in handbooks, case studies, and examples, being sensitive to the different experiences and positionalities of diverse groups (for example: names in handbook examples should represent the diversity of educators, students, and patients). Awareness of intersectionality is of particular importance as we navigate efforts to decolonise the curriculum
3	Include compulsory structural/unconscious bias or Equality, Diversity, and Inclusion (EDI) training sessions for educators and students
4	Acknowledge and discuss competing discourses on sex, gender, and sexuality, including the perpetuation of bias and inequity. Embrace the arts and humanities as a tool for creating safer spaces and an informal approach to discussing gender and associated inequities
5	Remember that addressing equality, diversity and inclusion is a longitudinal process. We are training the future policy makers; taking the time to sow the seeds and allow understanding to develop is crucial

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Chapter 11
The Philosophy of Agency: Agency as a Protective Mechanism Against Clinical Trainees' Moral Injury

Abigail Konopasky, Jessica L. Bunin, and Lara Varpio

11.1 Introduction

While the nature of agency is a lively debate (see Chapters 10 and 12), we define it for our purposes here as *the process of using one's resources to intentionally determine and pursue goal-directed actions amidst constraints* (Ermarth 2001; Martin et al. 2003; Konopasky and Sheridan 2016). In health professions education (HPE), the agency harnessed by learners has been closely linked to feedback, assessment, and learner growth and development (Sweet and Davis 2020; Tripodi et al. 2020). As these studies illustrate, drawing on conceptualizations of agency can offer valuable perspectives through which educators can face HPE's most intractable problems. Such "wicked problems"—e.g., teaching interprofessional education and professionalism, addressing racial and ethnic disparities, and designing effective remediation programs (Varpio et al. 2017)—often hamper clinicians' educational efforts. A particularly "wicked" problem that is receiving increasing scholarly attention is the moral injury of medical trainees (Murray et al. 2018; Murray 2019; Borges et al. 2020; Haller et al. 2020). Moral injury is defined as:

A. Konopasky (✉) · L. Varpio
Center for Health Professions Education, Uniformed Services University of the Health Sciences, Bethesda, MD, USA
e-mail: abigail.konopasky.ctr@usuhs.edu

L. Varpio
e-mail: lara.varpio@usuhs.edu

A. Konopasky
Henry M. Jackson Foundation for the Advancement of Military Medicine, Bethesda, MD, USA

J. L. Bunin · L. Varpio
Department of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD, USA
e-mail: jessica.bunin@usuhs.edu

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> the experience of guilt and shame (or profound psychological distress) resulting from violating one's morals and values during a severely stressful event. (Haller et al. 2020, S174)

Moral injury may also result from accumulated experiences as opposed to one severely stressful event. While associated with burnout—"a syndrome of exhaustion, cynicism and reduced efficacy resulting from chronic workplace stress" (Freudenberger 1975)—moral injury reframes the problem from one of a stressed out individual (e.g., who simply needs to do more meditation or relaxation) to the system that places healthcare providers in a position where they cannot abide by their values and moral standards (Dean et al. 2019). Episodes of moral injury result from understanding one's moral code and understanding the actions which are consistent with that code but being unable to accomplish those actions due to external constraints (Haller et al. 2020).

Below, we illustrate how theories of agency can powerfully support examination of HPE learners' moral injury, arguing that this injury can arise out of constraints on learners' agency. Trainees in various health professions may experience these constraints differently, but the existence of constraints on *exercising* agency is ubiquitous. Oncology fellows may be unable to prescribe an optimal treatment due to insurance limitations. Internal medicine residents may be unable to spend enough time caring for their patients due to excessive electronic medical record documentation and administrative tasks. Psychiatric residents may be unable to share information with family members despite a belief that the family may be integral to wellness. Similarly, nursing and medical trainees in the intensive care unit may be unable to permit family to visit with a critically ill patient due to a hospital's COVID-19 visitation policy despite a belief in the value and healing that might result for both the patient and the family. Repeated experiences like this can erode trainees' *sense* of agency, a complex, unfolding concept that is shaped by the discourses and contexts across their history (Van Alphen 1999). As described by Talbot and Dean (2018):

> Routinely experiencing the suffering, anguish, and loss of being unable to deliver the care that patients need is deeply painful. These routine, incessant betrayals of patient care and trust are examples of 'death by a thousand cuts.' Any one of them, delivered alone, might heal. But repeated on a daily basis, they coalesce into the moral injury of health care. (18)

Moreover, if traumatized trainees do not have a language for these "thousand cuts," they may give up their subjectivity altogether, abandoning a sense of either agency or victimization (van Alphen 1999).

In this chapter, we use the case of moral injury to illustrate how philosophical conceptions of agency can help educators support learners in HPE. We begin by setting out the problem of moral injury with a case drawn from critical care. We then address the problem of moral injury by drawing on two philosophical approaches to agency: (a) what moral and postmodern philosophers have said about what it means to *exercise agency* amidst the potential constraints of other agents of social and institutional structures and (b) what phenomenological philosophers have said about what it means to have a *sense of agency* amidst these constraints. We conclude by offering suggestions for how instructors can better support learners' sense of agency

to prevent moral injury, and how a nuanced view of agency, like the ones here, can shape HPE research and practice.

11.2 Case Presentation

An elderly male is admitted to the intensive care unit for respiratory failure and altered mental status in the context of a hospital admission for COVID one month prior. He has a complicated medical history, including active forms of cancer with an estimated prognosis of less than one year to live. Upon admission, he rapidly decompensates and requires intubation and invasive mechanical ventilation. Several days into this admission, despite being intubated, he has a particularly lucid day when he is alert and interactive with the medical staff. The bedside nurse in training spends several hours discussing his illness with him. She is convinced that he does not want to remain dependent upon machines for the long term, does not want a tracheostomy, and does not want cardiopulmonary resuscitation (CPR) in the event of cardiac arrest. She tracks down the medical team to include an intern, resident, fellow, and attending. The team reiterates the conversation with the same conclusions. The next day, the bedside nurse again broaches this conversation with the family present via video call due to the hospital's restrictive visitation policy during COVID-19. The patient, again, consistently communicates his wishes, but he appears less interactive. Over the next 12 h, the patient decompensates and is no longer consistently interactive with his care team. During follow up conversations with the family via video, the family believes that the patient's decisions were based on delirium and were only a snapshot in time. They believe that if he were to become more alert, he would most certainly want aggressive medical care and to be kept alive by all means possible to include tracheostomy and CPR. Through these conversations, it becomes clear that the patient had never told his family members of his cancer diagnoses, and that they had never previously had end-of-life, goals of care discussions.

The care team, determined to honour the patient's autonomy, obtains an ethics consultation. While ethics consultation services vary across national healthcare systems, the service represented in this situation includes a team of volunteers who may not have formal ethics training, but who provide an ethically based assessment from an uninvolved perspective. The ethics consultants in this case state that since there is no documented medical power of attorney, the wife's decisions stand. The ethics team further recommends a legal consultation, as is often the course in various healthcare systems. The legal consultants agree that, due to state policy, the family's interpretation of what the patient would want in totality outweighs what the patient requested when he was lucid. The team moves forward with a tracheostomy. Within a week, the patient is transferred to a long term ventilator weaning facility. Over the next few months, he repeatedly gets re-admitted to the hospital for infections. His care is optimized as much as possible, but he remains minimally conscious and does not interact with his environment in a meaningful way.

11.3 Agency Amidst Constraints: Normative Ethics and Postmodernism

As this case illustrates, the potential guilt and shame of moral injury may be interpreted as directly related to the *constraints on trainee agency* (e.g., being required to perform futile CPR) and their *experience of them* (e.g., profound distress for violating patient autonomy). While constraints are part and parcel of the experience of agency (see definition above) and health professionals are always able to use their agency to act against policy (e.g., refusing to perform CPR), this dissonance between self and system may be new and unexpected for trainees. Both moral and postmodern philosophers have wrestled with the problem of constrained agents: can one truly exercise agency amidst external constraints? If not, do the constructs of "right" and "wrong" truly have meaning? In this section, we review the ways moral philosophers have tackled the problem of *bounded* agency and how postmodern philosophers have dealt with what some posit as the *absence* of agency. We move to the experience of agency in the following section.

11.3.1 Consequentialist Normative Ethics: The Problem of Resource-Bounded Agents

For consequentialist moral philosophers (those focused on the effects of actions rather than a moral norm [Alexander and Moore 2021; See Chapters 15 and 16 for more discussion of consequentialist versus deontological philosophy]), the problem of agency originates in the agent: as humans, we are located in particular times and places with limits on what we can know (e.g., while I can know what I would want at the end of my life, I cannot know what all patients in all contexts across the globe would desire—i.e., it is impossible to understand all of the factors that contribute to patients' decision making) and on what we can process (e.g., even if I could interview 1000 patients, I do not have the cognitive processing ability to hold all of that in my mind at once to cross reference those sets of knowledge and understand "the" truth about end-of-life decision making). From this perspective, these moral philosophers ask: With humans' limited resources, are we truly able to exercise agency in deciding how we "should" act (Caton 2021)?

Philosophers have posed several solutions to this, with some schools (e.g., utilitarianism) arguing that a standard of optimal decision making is actually *immoral* because it costs so much time and effort in mere computation that could be spent engaging in other moral actions (e.g., in the case above, when the patient originally presented to the hospital and decompensated, it would have been immoral to debate the patient's end of life goals and code status with the family and other members of the care team. In reality, at that time, the preponderance of evidence available indicated that the patient was full code and therefore, immediate intubation was the moral action). In response to this senseless computation, Christopher Cherniak set

a standard of "minimal rationality," arguing that "there are often epistemically more desirable activities for [human agents] than maintaining perfect consistency [in decision making]" (as cited in Caton 2021). In other words, when I spend all my time deciding *how I should act*, I am taking no steps in the world *to actually act*. Instead, then, we must lower our standard and aim for "minimal rationality" that is "good enough," even relying on heuristics to make decision making "fast and frugal" (Caton 2021). Moral agents, then, determine an acceptable threshold of systematicity and only engage in computation to that level. As applied to the case above, finding no obvious documentation of code status and hearing from the family that the patient wanted to be intubated, plus understanding that the patient would rapidly die without action are "good enough" to make a decision on moral action. (See Table 11.1 for summary of philosophical approaches, principles, and examples.)

Table 11.1 Summary of philosophical approaches, principles, and clinical examples

Philosophical approach	Principles	Clinical examples
Normative ethics	Minimal rationality (i.e., "good enough" ethics)	Making clinical decisions without full information, e.g., intubating a decompensating patient with unknown code status or moving forward with an end-of-life plan of care without fully understanding all information
Postmodernism	Innovation and alternate discourses (to escape prison-house-of-language)	Weaving the discourse of palliative care (making the patient comfortable) into the discourse of critical care (encouraging them to "do everything") to move forward
Phenomenology	Intentional binding	Connecting the intention of empathic communication to honour autonomy with the outcome of ensuring the clinical team is aware of the patient's goals of care
	Purposiveness	Helping a student to retrospectively connect a somewhat haphazard conversation with the patient with the intention of helping the team understand the patient's goals of care
	Sense of control	Determining what information is necessary to place *any* consult (global planning); collecting the information and planning the script to deliver to ethics consultant for this *specific* patient (local planning); manner of communication during the act of consulting (sensorimotor planning)

In our case study, when the trainees on the care team are determining whether to move forward with tracheostomy and long-term care, apparently in opposition of the patient's wishes, they are operating with a limited knowledge set—as the family rightly points out, they cannot know what the patient *would* have said at some other point in his life. Moreover, particularly as individuals new to medicine, they cannot possibly be aware of or mentally compute all the aspects of this case, including consequences of the decision to the individuals involved (e.g., the patient, family members, and other stakeholders); the hospital policies; relevant laws; and their own career paths and possible good they might do for other patients in the future (which could be taken away if they act against the law). This is where the attendings, working together with a community of multidisciplinary clinicians and educators, can help the trainee develop a 'good enough' decision making process. The trainees demonstrated agency in their attempt to display the patient's wishes to the family via a video family meeting. They constructed a plan based on the information they had: the patient wanted to limit aggressive care and the family needed to know this information. While the conclusion of this meeting was not as expected, it is important for attendings to show appreciation for the proactive attempt and help trainees to understand that to exercise agency is not necessarily to reach one's desired goal. Allowing and encouraging trainees to arrange for and engage in family meetings and advocate for their patients is a form of agency that may mitigate the moral injury that might otherwise arise from this experience. Through this work with their clinical community, trainees can learn what 'good enough' decision making looks like. Finally, educators should keep in mind that what causes moral injury to one trainee may not to another—experiences of agency are tied up in an individual's past experiences and contexts (van Alphen 1999).

11.3.2 Postmodern Philosophy: The Prison-House-of-Language

While the problem of agency for utilitarian moral philosophers is primarily a computational one, for postmodern philosophers it is an issue of language and power. The term "postmodernism" literally signals the end of modernity's ways of thinking. In modernism, many "grand narratives" were constructed: e.g., science, reason, and truth. Postmodernists (e.g., François Lyotard, Michel Foucault, Jean Baudrillard) position these narratives as illusions that obfuscate or even hide the complexity of human reality. As Lyotard famously asserted in his text The Postmodern Condition, postmodernism seeks emancipation from the conformity imposed by these grand metanarratives: "I define postmodern as incredulity towards metanarratives" (Lyotard 1984). In other words, these grand narratives lost credibility once they were recognized as being merely that–narratives, stories, fictions. While we may

perceive ourselves to be making decisions that cause certain effects in our environment, postmodernists like those mentioned above posited that we are actually in a prison-house-of-language. Fitzhugh and Leckie (2001) describe it this way:

> Premise 1: Human thought is fully shaped by language.
>
> Premise 2: Any given language is a closed system.
>
> Conclusion: Therefore, thought is a closed system. Without access to anything outside of language, humans cannot act outside the system. (64–65)

Another way to think about it is that individuals live in a reality that they know and understand through the language and the narratives that surround them (i.e., the *discourses*—systems of meaning and value [Ermarth 2001]—they live in and through). Thus, individuals can't live or take actions outside that language and those narratives. For some postmodern theorists (e.g., Jacques Derrida), it is not possible to conceive of life or action without doing so through language.

What does this mean for postmodern conceptualizations of human agency? In this philosophical orientation, agency is a construct of the potentially shifting and changing discourses within which the individual lives. The context gives the individual a finite (and limited) set of linguistic tools (i.e., words and narratives), which are constantly subject to change. Since the individual can only work with those tools, agency is limited. Moreover, this limited agency is not distributed equally—those with more access to dominant discourses have more opportunities for agency (see Chapters 9 and 10 for more discussion of limits on agency). In our case, the trainees, in discussing end of life issues with the patient and the family, were operating within a discourse of modern Western medicine and more specifically, critical care medicine in the United States, with its structures of white supremacy (Ferrel 2017). The discourse of Western medicine functions to maintain power for some (e.g., administrators and physicians) and take power from others (e.g., patients, their family members, minority physicians [Wyatt et al. 2021]). If the trainees had been functioning within a palliative discourse, this conversation may have happened long before the situation became dire. The discussion of death and dying may have been normalized and built on over years instead of being constructed within one meeting. Whatever discourse(s) our trainees experience, they are operating within that closed linguistic system. Their agency is locked in the prison of the words and narratives of the contexts in which they live and work.

Thankfully, a number of postmodernist philosophers have pushed against this prison-house-of-language conundrum and made a case for human agency. For instance, Ermarth brings in Ferdinand de Saussure's notions of *langue* (i.e., the *potential* available in a system of language; e.g., all the possible goals of care discussions that might occur) and *parole* (the language as used in *practice*; e.g., all the actual discussions in existence). The distance between potential and practice means that language is "forever incomplete-able" (Ermarth 2001, 43). In other words, there is no complete version of "English" we can identify; rather, we infer the notion of "English" from our experience of it. Similarly, there is no complete version of "medicine" or "healing"; rather we infer the notion by our experience and practice of it. Our language is forever growing and evolving. It is not stable, nor is it ever

complete. It is in this incompleteness that the potential for agency lies: our linguistic potential lies beyond what has been said. Human agency lies in the potential that is distributed across all the speakers of the language as they bring that potential into practice, as they experiment with language (Ermarth 2001). Within this orientation of postmodernist philosophy, agency "is not a singularity, but a process, a happening, a particular expression of systemic value" (Ermarth 2001, 46) The postmodern agent is a "point of empowerment" who is both created by and creating the discourses around them (Ermarth 2001, 47). This is not to suggest that the agent is not limited; the agent is limited by the language that is available, by their ability to innovate, by their creativity. Rather than the modern agent who is stable and can take clear actions, the postmodern agent is "smaller, humbler, less passive, more creative, possibly even more effective" because they creatively bring together all the potential of discourses to craft their own narrative (Ermarth 2001, 48).

In the practice of critical care medicine within the discourse of Western medicine and more specifically, the United States medical care system, our trainees may be stuck in a prison-house-of-language if we, as their educators, do not teach them to creatively think beyond it. Trainees may feel limited in the degree of medical care they are allowed to provide within the scope of their training medical license. They may feel constrained by their role on the medical team and fear repudiation should they overstep. They may fear the litigation of medical malpractice if their plans result in untoward consequences or if they refuse to deliver futile care despite the family begging them to "Do everything."

The educators on the care team in our case have an opportunity to empower trainees to practice agency and innovation. While these trainees may indeed be limited by the scope of their license, the attendings can help them grow and develop mastery by ensuring they support their efforts and supervise them at appropriate levels. In our case example, this would be illustrated by appreciating the initiative that the nursing student took in having end-of-life conversations with the patient but offering supervision and feedback to help with future discussions. We should encourage and reward our trainees' initiative in developing rapport with patients, understanding their cultural context, and involving their families in their care—even when they approach it differently than we might or if the result is not as desired. We can demonstrate appreciation of the risks they are taking as they establish and practice their own style of communication and patient care. Another important intervention we can make for trainees is to have open conversations regarding difficult legal and ethical cases (e.g., the choice not to perform CPR on a full-code patient) that physicians have personally encountered and encourage trainees to share honest perspectives on how they might act. Most importantly, we must ensure that our trainees know that we, as attendings, carry the ultimate responsibility for our trainees and for our patients. The trainees in this case, for example, must understand that they will not be placed in legal jeopardy as a result of well intentioned, appropriately supervised decision making and patient care.

11.4 A Sense of Agency: Phenomenology

While normative ethics and postmodernism can help instructors to support trainees' exercise of agency amidst constraints, this process will be of little help in future situations if these trainees do not experience a *sense of agency*. To have a sense of agency for a given action is to feel that "I am the one who is causing or generating the action" (Gallagher 2012, 18), that I am the author of that action or, in the case of not doing CPR for instance, inaction (Pacherie 2007). Without this sense of authorship over action, trainees will not feel capable of initiating action. Unfortunately, a sense of agency tends to be "short-lived and phenomenologically recessive" (Gallagher 2012, 17). In other words, the feeling of agency that might come from completing actions across a day recedes into our experiential background and, when we do experience it, does not last very long. Phenomenological philosophers like Pacherie and Gallagher have argued that a sense of agency is not a single phenomenon, but can be separated into more basic component parts. Below we discuss three component parts these two phenomenologists offer that may be useful for supporting trainees as they develop a sense of agency in their work: intentional binding, purposiveness, and a sense of control (Gallagher; Pacherie).

11.4.1 Intentional Binding: Linking Intent and Outcome

Perhaps the most critical element that enables a sense of agency within Pacherie and Gallagher's phenomenological approach is noticing a link between one's *intention* to complete some action and the *outcome* or consequences of that action (Gallagher 2012; Pacherie 2007). For instance, the nursing student in our case study engaged in detailed, empathic communication with the patient to honor the patient's autonomy. The outcome in this case was that the medical team developed a deeper understanding of the patient, the situation, and the patient's goals of care. The *binding* between that intention (empathic communication to honor autonomy) and that outcome (ensuring the team knew the patient's goals of care) is the core of a sense of agency (Pacherie 2007). Instructors can help learners, in the midst of a busy day in class and/or clinic, to notice this link.

11.4.2 Purposiveness: Characterizing Action

While intentional binding is necessary to a sense of agency, Pacherie (2007) argues that it is not sufficient. In fact, in studies by Wohlschläger and colleagues (cited in Pacherie 2007), participants had the same response time when generating actions themselves as they did when watching others generate actions. These scholars suggest that this evidence implies that action/outcome binding is not necessarily linked to

the self. Another important element in a sense of agency revolves around the action itself and whether it is taken up with a goal in mind. Pacherie calls this *purposiveness*. To experience that feeling of authorship, the actions one undertakes should be goal directed. Had our nursing student not had the goal of addressing the patient's goals of care, she might have asked the patient haphazard questions. Instead, while the patient was lucid, alert, and interactive, she conducted a goal-directed conversation to understand the factors that contributed to the patient's end-of-life wishes. Instructors support trainees' sense of agency by supporting them in taking on goal-directed actions. Purposiveness can also be retrospective (Pacherie 2007): if a trainee takes action without consciously setting an intention, instructors can help them to infer an intention after the fact, which supports a sense of agency. Pointing out to the student nurse that in haphazardly asking questions they learned about the patient's cultural beliefs and perspective of life and helped the team better understand the patient, for instance, allows them to retrospectively infer purposiveness.

11.4.3 A Sense of Control: Global Planning, Local Planning, and Sensorimotor Representation

In addition to intentional binding and purposiveness of action, a sense of agency rests upon a sense of control: either *feeling in control* over a relatively expected course of events or *exerting control* amidst constraints (Pacherie 2007). Pacherie identifies three subtypes of control feelings people can experience: rational, situational, and motor.

Rational control aligns with what we may think agency feels like: it is development of a clear intention and a purposive action to carry out that intention; it can be concerned more globally with *types* of actions (e.g., "placing consults") versus tokens (e.g., "placing an ethics consult for this patient"); and it is subject to external pressures to be consistent and coherent (i.e., to be *rational* action). In our case, the intern experiencing rational control might be determining what information might be necessary to successfully place a coherent consult to the ethics team.

The next level down, situational control, is more local, more anchored in context, and usually much closer in time to carrying out the action. The same intern experiencing situational control would perhaps be collecting the information and planning the script they might deliver to the ethics consultant for this specific patient.

Finally, motor control involves our sensorimotor representations. One is not usually aware of this feeling of control (Gallagher [2012] calls it *pre-reflective*: either unconscious or peripheral awareness) *unless* something goes wrong. For instance, the student might almost unconsciously be speaking in an excessively loud, pressured manner when they call the ethics consultant until the consultant asks them to slow down and take a breath, bringing this action to awareness. All three of these levels of control are important for trainees to experience to have a sense of agency. It is not enough for a trainee to solely experience motor control, or even more reactive

situational control, but must also be supported in developing the skills to plan more globally so that they can also experience rational control (note that other philosophers have pushed back against this notion of control, noting that it is often illusory, e.g., elevator buttons that do not do anything [Žižek 1999]; see Chapter 17 for further discussion).

11.5 Conclusion

The exercise and experience of agency are fundamental parts of being human and, as such, are areas philosophers have been wrestling with for centuries. We have demonstrated here how two aspects of agency—the exercise of agency (discussed through consequentialist and computational normative ethics and Lyotard's postmodern theory) and a sense of agency (discussed through Pacherie and Gallagher's phenomenological approach)—can offer instructors valuable tools for helping trainees both to exercise and experience agency amidst constraints. We suggest through our case application that the exercise and experience of agency can be protective factors from the psychological distress of moral injury and that philosophical constructs can offer instructors tools to support this agency.

This case surfaced many areas that tend to create moral distress for health professions trainees: insecurity regarding their role on the medical team, inability to know and understand our patients' desires over time (we can only know how a patient answers a given question during their critical care hospitalization—their state of mind may not be at their baseline), inability to honour patient autonomy, being required to provide futile care, being unable to effectively communicate consequences of critical illness to family members, discomfort in discussing death and dying, being caught between the medical system and the legal system, and being unable to provide patients with dignity at the end of life. This case was further complicated by COVID-19 and the resulting inability of the family to spend time with the patient as well as the inability for the family meetings to occur face to face.

There are actions educators can take to reduce the likelihood that potentially morally injurious situations result in moral injury. Consistent with normative ethics and "minimal rationality" (Caton 2021), we are obligated to teach our learners to make decisions with incomplete information. The intensive care unit may require life and death decisions to be made in an instant. Further, we may have weeks to make decisions, but we still cannot learn all necessary information. Inevitably, we will all make bad decisions. We must teach humility, self-compassion, and help seeking skills to assist our learners in meeting this challenge and prevent them from becoming paralyzed from decision making by craving more information.

Following insights from postmodern philosophy, we must also empower our learners to practice innovation and creativity as they develop their craft and ensure we do not guide them into a prison-house-of-language. Instead, we must remind them that there are always alternate discourses to study, cultures to learn from, inventions to use, facts to discover, language to develop, and connections to make. There are numerous

opportunities to increase learner creativity and innovation to include poetic inquiry, innovation curricula, multimedia presentations of research, and medical improvisation and acting (Brown et al. 2021; Neel et al. 2021; Rieger et al. 2021; Wong et al. 2021). Consistent with phenomenology, we must teach them all stages of a sense of control in agency: global planning, local planning, and sensorimotor representation. Successful providers must learn cognitive reasoning, contextual and situational thinking, as well as procedural skills to practice agency—all are required.

While the three philosophical approaches to agency explored here (consequentialist computational normative ethics, Lyotard's postmodernism, and Pacherie and Gallagher's phenomenology) can offer powerful ways to support learners, agency is an incredibly rich construct that has been explored across other approaches to philosophy along with psychology, education, linguistics, and anthropology (Capps and Ochs 1995; Holland et al. 1998; Quigley 2000; Ahearn 2001; Rogers 2004; Bandura 2006; Chirkov et al. 2011; Heckhausen 2011). HPE scholars could mine these fields for insights to support them in teaching and research. For example, Holland and colleagues, coming from anthropology, argue that one way to exercise agency is by drawing on Bakhtin's notion of *heteroglossia*: "the simultaneity of different languages and of their associated values and presuppositions" (Holland et al. 1998, 170). They argue that the Naudadan women of Nepal use the songs they create for the annual Tij festival to engage these different languages, voicing the idea of the "good Hindu woman" from the public discourse while also *critiquing* it from their own embodied experiences (see Chapter 10 for more discussion of agency from a feminist perspective). In the health professions, we could use this approach to examine the ways learners may exercise agency by expressing their own embodied experiences in potentially contested spaces like clerkships (where trainees traditionally have little power). This could help us to better understand these learners and to provide support for their agency (see Bennett et al.'s [2017] analysis of two medical student reflections for an example of the use of Holland et al.'s [1998] notion of agency in health professions education).

An important contribution of philosophical approaches is that they illustrate the complexity of agency. Our application of philosophical constructs to the case demonstrates that agency is not a monolithic characteristic that is either there or not, but is instead a nuanced construct made up of different components that may shift across people and contexts. As health professions educators, we must consider what kinds of agency we can support for our learners across the environments in which they work. For instance, in a study of a GED program (adults seeking high school certification), Konopasky and Sheridan found that learners explicated different kinds of agency—and agency support—across times of their lives; they narrated themselves as facing insoluble barriers in their past schooling and experiencing almost endless support and possibility in their present GED program (Konopasky and Sheridan 2016). While much of their agency was individual back in high school (when they had little to no support), they used more joint or collective agency in their GED program (when they had tremendous support from family and friends). Thus, they approached each context as an agent differently in order to achieve their intentions. More nuanced constructions of agency could help us to identify the types of agency

Table 11.2 Practice points

1	The exercise and experience of agency are fundamental parts of being human and becoming a healthcare professional
2	Attendings or seniors who are cognisant of the external constraints that trainees experience can decrease the risk of moral injury to those trainees
3	Educators should show appreciation for proactive decision making by learners in the absence of perfect information
4	Educators must provide supervision and feedback to empower trainees to develop their own communication and patient care style
5	Educators and institutions should consider how trainees can be helped to experience a sense of control at the global, local, and sensorimotor decision-making levels

our health professions learners use across contexts and support them in strategic use of internal and external resources in reaching their goals.

A complex and nuanced approach to agency, like those offered by philosophy, could be particularly helpful with "wicked problems" like that of moral injury, that are social and even systemic in nature, resisting definitive formulations or explanations (Varpio et al. 2017). In order to address further problem spaces such as interprofessional education, racial and ethnic disparities, and remediation, HPE scholars need to approach the agents in these spaces as complex decision makers. These agents wrestle with changing constraints and shifting experiences of agency as they engage in the *process* of planning and carrying out purposive actions that are "good enough" to meet internal and external standards. We must offer our learners tools like agency to function in their complex and shifting environments, while helping them to understand that there is no *ideal* agent who can compute the "right" decision in every situation. Instead, agents are innovators, creators, who draw on an imperfect set of resources to craft a way forward amidst constraints and barriers, but with the support of other flawed agents like their peers and instructors (Table 11.2).

Disclaimer The opinions and assertions expressed herein are those of the authors and do not necessarily reflect the official policy or position of the Uniformed Services University, the Department of Defense, or the Henry M. Jackson Foundation for Military Medicine.

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Chapter 12
"What Does It Mean to Be?": Ontology and Responsibility in Health Professions Education

Tasha R. Wyatt, Rola Ajjawi, and Mario Veen

12.1 Introduction

Health professions education (HPE) has traditionally drawn from the practices and perspectives of biomedical science and cognitive psychology. These disciplines tend to privilege ontologies where there is an independent reality that exists 'out there;' scientists just need to use scientific methodologies to uncover nature's universal laws. However, this ontological realism has come with a cost in that it has positioned humans and non-humans in fixed and static ways, and has contributed to HPE's near disregard for the basic ontological question of, "What is it to be? What does it mean to exist?".

These questions are fundamental to any profession, however, as the field of HPE continues to become more racially and ethnically diverse, the field will need to expand its ways of doing ontology, and more deeply consider what it means 'to be' in HPE. As three HPE researchers who deeply consider issues of ontology in our work, we propose that educators ask ontological questions to allow for other conceptualizations of being, specifically by considering ideas around responsibility.

In this chapter, we adopt a philosophical orientation of ontology, where ontology is something you do rather than a lens or perspective you adopt or switch between.

T. R. Wyatt (✉)
Center for Health Professions Education, Uniformed Services University of the Health Sciences, Bethesda, MD, USA
e-mail: Tasha.wyatt@usuhs.edu

R. Ajjawi
Centre for Research in Assessment and Digital Learning, Deakin University, Melbourne, VIC, Australia
e-mail: rola.ajjawi@deakin.edu.au

M. Veen
Department of General Practice, Erasmus Medical Center, Rotterdam, The Netherlands
e-mail: m.veen.1@erasmusmc.nl

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We begin by describing what ontology is and why it is needed in HPE, and then elaborate on the idea of an expanded ontology that considers responsibility. We consider how 'being' might be described as a context within which everything else takes place, and a 'nothing' or a 'not-yet' within subjects, and how those in HPE might keep this space open for their trainees, peers, and patients, who are in the process of becoming someone/something. In introducing this expanded view, we hope that health professions educators will create space for trainees to be so that they might bring their whole selves to the profession.

12.2 What Is Ontology?

Ontology is a highly abstract branch of philosophy that might best be understood as the science of what is and the claims we can make about the nature of being and existence. It falls under the branch of metaphysics, which deals with the topic of being; the other branches include epistemology, axiology, and logic. Being, in a philosophical sense, represents a clearing or space within which anything can be true or false, present or absent, real or illusionary. For example, a lie—though false—*is* still as a lie; a character in a novel or a dream are not real, but they do exist as imaginary or dream figures. Further, an event in the past or the future does not exist now, but it 'has being' as a memory or a future possibility.

As such, ontology concerns itself with questions of being in relation to other beings such as, "In what way do future possibilities exist in contrast to actual events, or the past compared to the future, or human beings compared to animals, inanimate objects or technology?" Even more fundamental, "What is this 'being' that tells lies, dreams, engages with past and future events, material objects and other beings? What do these beings have in common?' and "What is the relationship between 'being' and 'becoming'?".

Given its abstract characteristics, one way to visualize ontology is to recall an experience in getting to know someone and the process that one goes through as an acquaintance moves into being a friend. Initially, most people think about these acquaintances in terms of the categories to which they belong; male, in their thirties, a physician, born in this place but emigrated to another place, soft-natured, etc. However, as this person becomes a friend, these categories disappear, and the person is thought about in terms of who they are. Categories and labels are no longer needed because in the process of getting to know someone better, space has been created for them to construct the nature of their being.

In similar terms, asking ontological questions, such as "What is a person? What constitutes a person?" can be a way to intentionally create this space for ourselves, and others, in which being can emerge. This can be incredibly challenging because humans have the tendency to use rigid categories and labels for organisation. For example, in HPE, trainees are often thought about in terms of categories (e.g., 2nd year student, Hispanic), qualities (e.g. smart, self-directed), or markings that are added on to the trainee in addition to other qualities (e.g. leader). Labelling trainees

has implications for conceptualizing when students become healthcare professionals, which is typically thought of as when they complete their professional training. This conceptualization sits in contrast to other potential ontologies, such as the idea that students already have a professional identity, one that has provided guidance and support to them in their journey to and through their professional school. They are not 2nd year Hispanic students who are smart and self-directed on their way to become a leader, rather they are already physicians, nurses, dentists, etc. in the process of becoming.

Doing ontology asks educators to listen to what people say about themselves and who they are becoming, rather than putting them into categories. Doing so requires engagement with another dimension; a movement behind or beyond labels to ask questions, such as, "What do I mean by this label or category? What is this that I am inquiring about?" Asking these kinds of questions is important because categories bring 'baggage' and assumptions—when we rely on mere categories, we overlook the fact that our interpretations rely on our understanding and engagement with ontology. For example, given that HPE thrives on data-driven approaches (e. g. scientific data, educational data, experiential data), doing ontology would ask why this data is useful; not "usefulness" in the traditional sense of doing something with the data, but rather in the sense that it might do something with us, how we see the world, and lead to new possibilities (Heidegger [1927] 2008).

However, to engage in this kind of questioning, educators must first acknowledge their own ontology, where it originates, and how it might constrain their views of others. This is inherently challenging because humans have a "philosophical bias [:] basic implicit assumptions...about how the world is (ontology), what we can know about it (epistemology), or how science ought to be practiced (norms)" (Anderson et al. 2019, 2). This philosophical bias determines some of the fundamental ways in which we make sense of reality.

HPE's ontology emphasizes separateness between beings with little consideration to issues of relationships, positionality, and interaction (Dornan et al. 2008; Kuper et al. 2007). Although these are increasingly recognized in HPE, ontologically speaking they are recognized as important 'on top of' the supposedly more fundamental separateness and materiality. In other words, HPE views that first there were objects, and then people could form relationships with them. However, this perspective effectively ignores the relationship between beings and the ways in which they mutually influence each other.

Separateness is emphasized within HPE because its dominant ontology is akin to that of a rational subject in a cockpit looking out of a window (Crawford 2016); an idea that draws from Locke and Hume's views of empiricism[1] that the world consists of matter and facts. Subjective views are positioned as obstructions to knowing the world that exists outside the window, which can be understood only if individuals are able to see reality for what it is—concrete, tangible, and independent from one's narrow perspective. Expanding further on Crawford's metaphor, objectivity is the

[1] Empiricism is a philosophical stance asserting that all knowledge is rooted in experience and that there is no knowledge beyond what can be empirically observed about the world.

degree to which the window is clear, whereas subjectivity clouds or in some way filters it. From this dominant ontology in HPE, we are thought to be wearing coloured glasses—if we can just manage to take off these glasses, we will be able to see the world objectively.

This dominant ontology is clearly seen in HPE's focus on individual autonomy and its tendency to view students as cognitive entities apart from their environment—a view indebted to Kant. This view is problematic because it positions students as empty vessels to be filled with information, who are ecologically isolated from their larger communities. However, there are alternative ontologies that might be helpful in rethinking the ways HPE views students and education; alternatives that emphasize individuals' relationships to the collective, including the ways we frame relationships between systems and individuals within those systems. To understand this framing, we will briefly describe who we are as researchers and the work we do in HPE, which, in turn, informs our thinking.

12.2.1 Responsibility as Ontology

As researchers, we espouse the idea that responsibility should be included in the ontological thinking embraced by HPE. Each of us has arrived at this perspective in our own research and work. Mario Veen came to HPE research from a background in interdisciplinary philosophy and the humanities, with a special focus on metaphysics and ontology. His view on philosophy and the role it can play in HPE can be traced back to three experiences. The first is being introduced to philosophy through an intense month-long undergraduate summer course in which students would read the work of one philosopher each day. Thinking about contrasting ontologies engendered the question of how to acknowledge relativity without succumbing to relativism (i.e., asking fundamental questions while still having a foothold). The second was the experience that the most valuable insights do not come through only 'intellectual' work, but involve one's entire being, including our emotions and our physicality. The third is being exposed to different cultures through travel and realizing the privileged position of being born in a Western country with access to commodities that most of the world does not have.

Rola Ajjawi is a physiotherapist, clinical educator, teacher, and researcher. Her PhD opened a new world of philosophies of science that were all but ignored in her original 'science' degree. The absence of thinking about ontology in HPE has been a constant nagging force for her research. Being an Australian immigrant whose parent was a refugee has given rise to many research questions around becoming, identities, belonging, and relating. Rola's current research asks about embodiment in hybrid learning, where time, space and place constitute identity, belonging, and being. She also analyses the ontological question of what it means to be human in

a post-digital world, and the implications and responsibility medical educators have for designing effective learning environments.

Tasha Wyatt is a teacher and researcher who studies the professional identity formation (PIF) of Black/African American physicians and their experience in training and practicing in a primarily white profession. Tasha infuses her work with ontological questions and the importance of responsibility in the process of becoming a physician and serving one's community. Her views are grounded in her experiences of growing up in Hawai'i during the 1980s, which at the time was going through a cultural renaissance. Native Hawaiians were emerging with a sense of self-determination after more than a century of colonization that had removed Native Hawaiians from positions of political leadership (Young 2006).

This re-emergence of Native Hawaiian values and practices heavily influenced the public educational system, most notably in the schools' curricula. Leaders espoused the idea that to create different kinds of beings, the school system needed to think about the purpose of school on their own terms (Wilson 1998). As such, they began to emphasize the indigenous value and practice of relationships and taking responsibility (Wilson 2008). The concept of kuleana, which emphasizes the existence of a reciprocal relationship between those who are responsible and the thing which they are responsible for became part of the school's values and mission. Children were explicitly taught what their kuleana was and how they should demonstrate it in a way that emphasises honouring oneself, others, and the land upon which they lived.

This deliberate political and cultural movement was deeply intertwined with issues of ontology, what it means to be or exist, and what role responsibility plays in this process. Educational leaders clearly understood that to change Hawaii's cultural and political future, the educational system needed to educate the next generation to think about and practice new ways of being. Unlike HPE, which tends to think of students as autonomous beings separate from their larger contexts, the idea that individuals have responsibility to themselves, and others places humans in a larger ecosystem that changes the way people relate to each other. Tasha has taken this idea of being and responsibility into medical education, specifically into her research on how the PIF experiences of Black/African American physicians is different because they view who they are and the work they do as physicians as ontologically different than the views espoused in the medical profession.

Outside our personal research on issues of PIF, relationships between people and objects, and hybridity in learning, there are several ways in which ontological responsibility might be interwoven into HPE. In what follows, we present three thinkers whose ideas contrast with HPE's dominant ontology. Our aim is not to give a historical overview of ontological thought, but rather to take three ideas that can stimulate ontological questions regarding responsibility in HPE.

12.2.2 The Ontological Approaches of Heidegger, Latour, and Barad

Heidegger, Latour, and Barad are three philosophers whose ideas have direct implications for thinking about ontological responsibility in HPE. Their work actually differs on several key issues, however common to them is the rejection of ontological dualism,[2] most associated with Descartes, who emphasized the distinction between the somatic (body) and the psychological (mind). Descartes' philosophy was more subtle than how it is portrayed; however his work has been interpreted as a view in which the world exists of mind and matter, the inner world and the outer world, the objective and the subjective. In departing from dualism, we can formulate key insights about doing ontology in HPE in a different way to what has been handed down by dominant biomedical models. Rather than orienting to individual minds and bodies, we assume actor-networks, entanglements, or assemblages of relations between bodies, things, ideas, and social formations that affect each other. To do this kind of ontology, individuals must start with themselves and where they are. They must approach their inquiry with an attitude of openness and be aware that the social and the material, values and science, are entangled and that there is no default choice in how to resolve these issues. Doing ontology is an ongoing practice of remaining aware of, and taking responsibility for, enacting decisions on what it means to be.

The first set of ideas that links ontology to responsibility is found in the work of Martin Heidegger, whose notion of being-in-the-world has led to current notions of embodiment, embeddedness, and positionality, which have also found their way into HPE. Heidegger's nineteenth century seminal work Being and Time (Heidegger [1927] 2008) marked a return to ontology after a period in which philosophers like Descartes and Kant had approached ontology as metaphysics, that is, as a way of building systems of categorization from a seemingly neutral 'outside perspective.' Heidegger's claim that our being is fundamentally being-in-the-world emphasizes the idea that we already stand in a fundamental relationship to other beings; we are not isolated subjects (outside of), but co-determined by others, tools (technics), and objects. Therefore, the highest form of knowledge is to gather lived experience, especially as it relates to self. In experiencing the world, an individual creates new possibilities for thought and action that help to reconsider their position and the way in which the individual wants to interact within it.

Heidegger describes human beings as 'having their being before them' in the sense that we are responsible for our being. This does not just mean our 'individual' being as a person, but our whole being-in-the-world, including its facticity; the state of affairs that was already there in the world when we entered it, and includes the past that informs the historical situation in which we live. This perspective has relevance for HPE, particularly in relation to PIF, whereby a trainee will enter professional

[2] Ontological dualism is any kind of ontological perspective that starts with 'there are two kinds of beings, namely…'. Typical examples are: spirit and matter, mind and body, God and world. Ontological *monism*, in contrast, is the view that everything in existence is the manifestation of one (type of) being.

school and treat the existing structures as something that has always been there and that they merely need to train themselves in, copy, and emulate.

Typically, students unreflectively inherit the entire past of HPE as crystallized in the professional school they enter. However, rather than thinking about PIF as a passive process of absorption or internalization, identity construction can be reformulated as a process of taking responsibility for that 'facticity'—the tradition they have entered and the past they have not lived. They could take ownership of being a trainee who has ultimate responsibility for the kind of physician they will be for their patients. This involves critical thinking and dismantling 'the way things are' (Paton et al. 2020), but also the realization that they are the ones that will 'be' the profession when they graduate.

The second set of ideas that links ontology to responsibility is found in the work of the French philosopher, anthropologist, and sociologist Bruno Latour. Central to Latour's perspective is that facts are not something that are uncovered in a laboratory, so much as produced or constructed by communities of scientists (Latour 1987). He argues that facts do not exist in and of themselves and challenged the distinction between science and culture (Latour 1993). He views nature and culture as inextricably intertwined into a matrix of social and cultural elements and underscores the need to include things (materiality) in our thinking and decision-making, as well as taking stock of the consequences of our actions. The concept of symmetry (that humans and non-humans are equally agentic) and flat ontology (that all beings exist on the same plane—none are more real or valuable than another) underpins ideas in actor-network-theory, where materials and humans are both actants who can effect change prompting questions of what is done rather than what is intended (Latour 2005).

Latour's contributions were that materiality is not neutral, and any material way in which we organize HPE has consequences. Curriculum, assessments, clinical experiences, and their interactions shape students in different ways that have both desirable and undesirable outcomes. Educators, therefore, have responsibility to think about the agency of materials that constitute the educational endeavour. For example, in their sociomaterial ethnography, Macleod et al. (2019) show how video conferencing technology—a network of buttons, screens, microphones, cameras, and speakers—far from merely extending the bricks-and-mortar classroom, operate as unintended "technologies of exposure." Pressing the 'button' to ask a question operates a video which beams a student's face into a lecture theatre, leading to lack of question asking. In another example, the checklist in an Objective Structured Clinical Examination (OSCE) station agentically shapes the assessor's actions and together constitutes competence of the student through a chain of interconnected activities (Bearman and Ajjawi 2018).

Recently, because of Latour's emphasis on the relationship between nature and science, he has brought attention to what he calls "a profound mutation in our relationship to the world" (Latour 2017, 8). In reference to issues such as climate change, he argued that the world in (and planet on) which we live can no longer be seen as a stage on which our human lives play out. Instead, humans need to consider their decisions on the planet in ways they have not had to before or, in his words, "the

décor [has] gotten up on stage to share the drama with the actors" (Latour 2017, 3). As climate change continues to affect human health, HPE will need to think deeply about the relationship humans have to the environment and the ways that the two interrelate. Responsibility in this context means that HPE will need to more deeply consider how our collective actions influence the environment because essentially there is no 'neutral' way of being. Even resignation or avoidance of issues, such as climate change, is still a way of relating that has consequences (Wellbery et al. 2018), which was recently discussed in terms of whether to keep medical resident interviews remote or resume in-person interviews once the COVID-19 pandemic subsides (Donahue et al. 2021).

Finally, the third set of ideas that links ontology to responsibility is found in the work of Karen Barad, who developed her ideas against the background of Heidegger and Latour amongst other feminist works such as Haraway and Butler (Barad 2007). She is a physicist and American feminist theorist who posited that the world is made of entanglements of "social" and "natural" agencies and the importance of studying these interrelationships. To Barad, responsibility (or response-ability) literally means the extent to which we respond to the world and the world responds to us. She underscores that, even in physics, there is no stable material world on the one hand, and a social world on the other. Rather, the world consists of relationships, or what she calls intra-actions. She uses this term to replace 'interaction' to emphasize that agency is not an inherent property of beings, rather it is a dynamism of forces. For example, even when educators think they are not participating in a clinical encounter while observing their trainees interact with patients, they are in fact a part of the dynamic forces in the room (Rietmeijer et al. 2021). From Barad's perspective, all beings are in relation to each other whether this is recognized or not.

In theorizing the importance of relationships, Barad (2007) also emphasizes what she calls agential realism, which examines "the material nature of practices and how they come to matter" (45). In Barad's relational ontology, matter and meaning are not separate elements and 'agency' is not an attribute of something or someone. Rather, agency is the process of cause and effect or what might be called an enactment. For example, in doing archival research, Tamboukou (2014) described how the process of reading and interpreting others' stories, researchers engage in intra-actions between space, time, and matter that draws attention to what kinds of data are gathered and knowledges that are derived. Individuals thus have agency, which is thought of as "'doing' or 'being' in its intra-activity" (Barad 2007, 178). It is through these entanglements of matter, "possibilities for worldly re-configurings" as agency emerge (Dolphijn and Iris van der Tuin 2012, 55).

In the context of HPE, this means that the object of knowledge cannot be separated from the practice, or phenomenon that makes it known. HPE should not be viewed as a collection of people, buildings, technologies, values, etc. because ontologically there is no clear distinction between these things. Rather, because medical students train in buildings, which were designed in ways that constrain and afford different ways of being, we cannot think about the medical student in isolation. They must be considered in relation to all of the other elements the student interacts with both human and non-human in the consideration of the optimal training environment.

In medical education, Barad's work has been used by Johnson (2008) to theorize the 'validity' of a gynaecological simulator, which might be thought of as politically neutral, but, in fact, has political dimensions. Specifically, in Johnson's study, the pelvic simulator simulated the pelvic anatomy as known in a US pelvic exam, not a Swedish pelvic exam. Johnson (2008) notes "acknowledging the fundamental aspects of practice in simulator development creates the discursive space to ask whose practice is being simulated?" (124). Given that practices are context specific, there is a political implication to constructing simulators that recreate and represent certain practices as medical norms, raising the question about the role of technology that might have been previously thought of as neutral:

> Understanding that simulators are representing practice means that we must start to think about which practices are being recreated and taught to new medical practitioners, and start to ask how and why these practices are being standardized, rather than assuming that the simulator apolitically and objectively mimics an ontologically 'true' patient body. (Johnson 2008, 123)

While Barad's insights are that matter matters and that relationality and agency are fundamentally political, Latour's notion of symmetry hides issues of power in our relationships with the world because all actants are equally agentic (Johnson 2008). Power cannot easily be located, making it difficult to challenge. Barad coined the term "ethico-onto-epistem-ology" to highlight entanglement around issues of power, undergirding the idea that the way we relate to being (ontology) has consequences for how we weigh different ways of knowing (epistemology) and which actions we can or cannot take (ethics). In other words, any new technology we adopt in medical education, the methodologies we prefer within research, and the way we assess students (and thereby make claims to what kind of knowledge are relevant) are all entangled. These decisions help to shape the kinds of individuals our professional schools produce, and the ways they, in turn, relate to other beings in the profession.

12.3 Future Directions for Expanding Ontology in Medical Education

The implications of doing ontology are significant for HPE, yet the influence of individualism within the field remains clear. HPE's focus on knowledge or skill as discrete and measurable components or superficial features of what it is to be a doctor have preoccupied much scholarship and curricular design. As Weston (1988) put it: "The missing dimension in medical education is the person, both the person of the patient and the person of the student. The experiences of both are the very foundations of learning, growth and healing" (1701).

We have seen a shift towards emphasis on the being as well as 'doing the work' of the physician (Wald 2015), especially in the shift from focusing on professionalism and professional behaviour to the development of a professional identity. Medical

education now sees that being a physician is not just a matter of being a professional, but rather a constant state of becoming one. This metaphor of becoming, alongside acquisition and participation might guide a change in pedagogy that favours a more developmental approach to thinking about how physicians are created. Learning as becoming (Hager and Hodkinson 2009) respects the entangled, reciprocal and dynamic interrelations between individuals and their learning cultures during the learning process; hence preserving complexity. From this perspective, development arises both from within and in relation to others (Kilbertus et al. 2018).

However, to shift to a focus of ontological responsibility, HPE will require a concerted effort to think about how curriculum might engage the whole person, integrating what the students know, how they act, and who they are; Dall'Alba refers to this as a pedagogy of responsive attunement to what matters (Dall'Alba 2020). Rather than assessing for authentic reflection, HPE students and educators can instead reflect on authenticity (whether they feel alignment with who they are) and inauthenticity, to contribute to the development of a professional identity (Veen 2021).

Thinking about identity in this way has consequences because identity is not a destination; it is a process in flux—one that involves integration of knowing, acting, and being in the form of professional ways that unfold over time. Expanding our view of ontology in HPE is particularly important as the field considers the PIF of minoritized physicians who come to the profession with different values, commitments, and aspirations than what has traditionally been seen (Wyatt et al. 2020a, b). Black/African American physicians do not fit the professional identity scripts that have been handed down through the profession, and their resistance to these scripts reveals how stifling they can be for those who do not fit the historical norm. As HPE begins to recognize its own entanglement with its history, it will need to rethink its curricular choices, and ask new ontological questions that take into consideration the perspectives of those who have been historically excluded from the profession.

Of course, these kinds of considerations for change are political. How much time and space are allocated for certain sub-disciplines is a political question, as is who is accepted into, and who graduates from, our professional schools. Additionally, assessment practices, which have hierarchical disciplinary functions (Foucault 1991) have the power to transform behaviours and shape identities to suit the sanctioned norms of the institution. Even feedback, the opportunity to tailor the curriculum to the individual student and encourage learning, can be a tool of control and disciplining in one's own image. However, educators can make subtle shifts in their thinking and interactions to create a clearing or space for students to begin questioning who they are in relation to themselves and others. It requires that educators practice ontology by being interested in beings they encounter, including themselves, a fundamental openness or an attitude of 'I do not know who this trainee, or what this new technology is,' and then remaining open to what is shared in this interaction. Fundamentally, practicing ontology is asking questions with the purpose of keeping the clearing open.

Table 12.1 Practice points

1	Ask ontological questions by starting with yourself and where you are
2	Ask yourself what the ethical and material consequences are of categorizing trainees and other aspects of your work in a certain way
3	Notice the entanglement of matter and social relations, and the borders between different ontological categories (e.g. technology and human)
4	Decentralize the human as individual in scholarship and focus on the relationship (and politic) between beings
5	Find ways to create *space* for trainees and physicians to bring their whole selves to the profession

12.4 Conclusion

Although HPE is built on an ontology of dualism and prefigured objectivity that has the potential to limit who others might become, thinking about being as a clearing or space in which students become who they are challenges this traditional framing. In hopes of thinking about ontology in a new way, we have forwarded the idea of responsibility as a focal point in these discussions. Doing so shifts the ontological 'unit' away from an entity to a relationship, so that how an individual relates to others or to their environment is not 'additional' to who this individual is, but rather it determines who they are and co-determines others and their environment. Further, we are never innocent bystanders of the world in research and practice, but always in a relationship with it, with responsibilities for others.

If there is one thing that this brief discussion of ontology shows, there are different ways of answering ontological questions, but what matters more than answering these questions is to ask them in relation to our everyday practice. We always relate to being in a certain way and this means that we are responsible for how we do ontology. In essence, we are always doing ontology, yet we are doing it either by inheriting the perspectives of others embedded within the profession, or we take it upon ourselves to consciously do it in a way that supports the goals we have for our students. Given the changing landscape of HPE, we hope that the community considers expanding their current ontological perspectives to include the idea of responsibility (Table 12.1).

Disclaimer The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.

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Chapter 13
The Philosophy of Science: An Overview

Amelia Kehoe, Charlotte Rothwell, and Robyn Bluhm

13.1 Introduction to the Context of Health Professions Education

> Medical [health professions] education is a complex interweaving of the sciences and arts of education and medicine. At its heart is the welfare of human beings. (Tan et al. 2011, 15)

Regardless of which health profession we are working in, or what our educational or research approach is, we all have the same goal: to ensure the safety and wellbeing of our patients, clients, staff, and students. Research is a crucial and fundamental activity in this goal, being the practice of critical or scientific inquiry.

Whilst there has been a shift in opinion in recent years, for a long time, the 'scientific method' that applied to the study of the natural sciences was considered the 'best' method (Bunnis and Kelly 2010; Park et al. 2020). This natural science approach largely utilises quantitative methods, involving the collection and analysis of numerical data for statistical analysis. Qualitative methods, on the other hand, involve the collection and analysis of non-numerical data (for example text or audio) in order to understand experiences, concepts, opinions, etc. Qualitative methods such as participant observation have historically been deemed less scientific and weak in comparison with quantitative methods (Bunnis and Kelly 2010).

A. Kehoe (✉)
Health Professions Education Unit, Hull York Medical School, University of York, York, UK
e-mail: millie.kehoe@hyms.ac.uk

C. Rothwell
NIHR Applied Research Collaboration North East and Cumbria, Newcastle University, Newcastle upon Tyne, UK
e-mail: charlotte.rothwell@ncl.ac.uk

R. Bluhm
Department of Philosophy, Lyman Briggs College, Michigan State University, East Lansing, MI, USA
e-mail: rbluhm@msu.edu

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From the 1970s, however, researchers in the social sciences, including education research, began to think about just how appropriate traditional scientific methods were for certain lines of inquiry. A debate over the appropriateness of the natural science model for social sciences enquiry gained momentum (Illing and Carter 2018), and there was a change in the way we viewed best practice in research. Arguments largely centered on the differences in focus; *people* in education and the social sciences, versus *objects* in the natural sciences. The terms 'qualitative' and 'quantitative' signified more than different methods of collecting data; they indicated different assumptions about how to conduct research in the social world.

What is quite sad, however, is that, for many years and still often now, health professions education research has been deemed as the 'poor relation of medical research' compared to quantitative exploration and quantifiable outcomes, due to its focus on 'people' and exploration beyond statistics (Bunniss and Kelly 2010, 358). This is, in part, due to health professionals often coming from traditional science backgrounds through which they may not have had chance to amass knowledge of the social science theories often explored within health professions education (Rees and Monrouxe 2010; Kajamaa et al. 2020). There is certainly a lack of knowledge of the philosophy of science among those who dismiss this type of research. Thankfully, the negativity towards health professions education is no longer overwhelming, with educational and, in particular, qualitative educational research, continuing to increase in popularity as its importance becomes evident. Often, issues or dissent raised regarding qualitative educational research stem from a lack of understanding about the importance of qualitative approaches and their role within the research world, along with individual attitudes towards the chosen research methodologies. We will discuss later in this chapter how we can help to improve this perception by ensuring we follow the necessary processes when conducting and writing up our research.

13.2 What Is the 'Philosophy of Science' and Why Is It Important?

The philosophy of science aims to understand how science works, asking questions about (e.g.) the nature of theories and explanations, how data support theories and explanations, and how methodological choices by scientists shape the data collected and the evidence they provide for theories and explanations (Machamer and Silberstein 2008). Philosophical perspectives are crucial as they can identify or provide assumptions and frameworks that guide our research. Philosophical perspectives are the starting point on which assumptions about research are based, influencing the researcher's role, how the study is carried out and the type of knowledge produced. Bourdieu (1991) describes philosophy of science perfectly as

> the principles of the construction of the object of study as a scientific object and the rules of delimiting the relevant problems and methods that must be employed to resolve them and to measure accurately the solutions. (14)

Within social and educational research, a vast literature on philosophy of science has developed, in large due to qualitative researchers trying to articulate (and to defend) the value of their research.

Mouton's (1996) '*Three Worlds*' Model is a useful way for us to begin to explore the idea of philosophy of science, distinguishing between different practices, rules, skills, and role expectations associated with the different positions regarding the nature of reality and nature of knowledge construction.

- *World one* (everyday life e.g., during our health profession education; pragmatic interest). World one consists of the objects of everyday life: individual human beings; groups; social practices; institutions; and the elements of our physical surroundings—essentially the things we typically consider make up our social and physical reality. In World one, peoples' experiences, engagements with learning, and self-reflection, contribute to the creation of problem-solving knowledge which is directed at coping with daily tasks and challenges.
- *World two* (science and truth e.g., health professions education research; epistemic interest). The phenomena of World one (everyday life) are transformed into objects for systematic and rigorous study; scientific objects of investigation. The motivating epistemic interest here is the desire to produce a truthful understanding of the operations of the natural and social worlds. World two consists of the academic disciplines of the social, human, and natural sciences; different methods for investigation; scientific hypotheses, models, and theories; and all the objects of World one. This world is ultimately built up of scientific knowledge, scientific disciplines, and scientific research.
- *World three* (philosophy of science and critical/reflective inquiry e.g., discussion of the philosophy of health professions education). The phenomena of World two (science) are explicitly transformed into objects of reflective inquiry driven by a critical interest, aiming to criticise, dissect, deconstruct, or analyse what scientists do towards the ultimate improvement of science. World three consists of academic disciplines like the philosophy of science, the sociology of knowledge, and the history of science; diverse research methodologies broadly guiding scientific inquiry (e.g., positivism versus interpretivism); research ethics, and all of the objects that are present in World two.

Of interest to us here is the fact that the aforementioned theories, models, and typologies exist within a body of knowledge within World two's realm of science. Attitudes of (e.g.) positivism and realism are placed as part of the meta-science in World three. These worlds that have been presented are merely a useful way for us to make sense of how we acquire our knowledge, and act as a guide within our health professions education. Ultimately, the philosophy of science is the very definition of 'science'—what it is and how science operates, both in theory and in practice. However, scientists often ignore the concepts, assumptions, ideas, and theories that

they use to make sense of the world and their research, ignoring the very *essence* of the philosophy of science.

13.3 Understanding Research Paradigms

The concept of a paradigm has been extremely influential in the philosophy of science. It can be traced to the physicist and historian, Thomas Kuhn, in his book, *The Structure of Scientific Revolutions* ([1962] 2012). Kuhn's use of the term 'paradigm' in this book is notoriously unclear (Masterson 1970). In a postscript to the second edition of the book, however, Kuhn clarified that there are two main senses or meanings of the term. First, a paradigm can be an exemplar: an illustration of how to solve a particular scientific problem. Second, and more important for the topic of this book, a paradigm can be a worldview shared by a group of scientists; a shared paradigm gives scientists a way of understanding their area of research, and also of evaluating research done in their field, because it provides a set of common beliefs and agreements about how problems should be understood and investigated, which ultimately shapes what we are able to *do* about those problems. According to Guba (1990), research paradigms can be characterised through their ontology (what is reality?), epistemology (how do you know something?) and methodology (how do you go about finding it out?). We will discuss these terms in more detail in the next section of this chapter.

13.3.1 A Closer Look at Ontology, Epistemology and Methodology

Scientists rely on a number of beliefs and assumptions to carry out their work, which they may explicitly endorse, or which may remain implicit. Many of these beliefs can be categorized as belonging to (or expressing) their ontology or their epistemology. There are also several overarching perspectives or philosophical stances that have been articulated in the philosophy of science developed by qualitative researchers; these encapsulate particular ontological and epistemological positions that inform the resulting research methods (Illing and Carter 2018). Here, we explain the concepts of ontology and epistemology, and provide an overview of several influential philosophical stances.

13.3.1.1 Ontology

Ontology, in general, is concerned with the nature of what exists. It raises questions about the nature and form of *reality* and about what can be known about it. Different sciences focus on different aspects of the world which make up the 'reality' for that

science. Physicists, for example, aim to uncover the nature of the physical world, including matter, energy, and fundamental forces. Neuroscientists aspire to explain how the brain works, in terms of such entities as neurons, transmitters, and neural circuits. Sociologists try to discover the structures and untangle the influence of social relations, social interaction, and elements of culture; this is also often the job of medical and health professional educationalists. In each science, the aim is basically to make sense of the nature of reality and of the objects and processes that take place within it. Ontological problems therefore rest at the heart of science; as we try to identify the various entities in the world and explain the way those entities work.

13.3.1.2 Epistemology

Epistemology is the study of *knowledge*; it aims to identify what counts as knowledge, how we acquire knowledge, and what it is possible for us to know. How researchers address these epistemological questions, however, is related to their answer to the ontological question (Moon and Blake 2014). Stemming from ontology (what exists for people to know about) and epistemology (how knowledge is created and what is possible to know) are our philosophical perspectives, as mentioned previously; a system of generalised views of the world, which form beliefs that guide our action (Moon and Blake 2014). As we noted above, quantitative approaches are central in the natural sciences (e.g., Physics), whilst qualitative methods are needed to investigate many aspects of social, including educational, phenomena. This distinction also shows that the methodological approach taken by a researcher follows the answers to the ontological and epistemological questions discussed above (our philosophical perspective), focusing on why we have chosen the methods, or tools, that we have to acquire our knowledge.

It is important to note that *methods* are merely the techniques that are used to gather information. Methods are not the same as *methodology*, which refers to the study or discussion of methods, such as which ones are appropriate for a study and why.

13.3.2 Overview of Philosophical Stances Within Research

At a more abstract level, different ontological and epistemological approaches also differ with regard to their views on the nature and knowability of the world in general (as well as with regard to the specific phenomena of interest to a researcher in a particular area of science). This is the level of philosophical stances or paradigms. These stances can be identified on the basis of their answers to ontological questions such as "Is there a 'real' and a single reality?" and "Are there multiple realities dependent on whose view is being taken?", and to epistemological questions such as "Is what can be known about the world independent of any relationship between the researcher

and the subject of inquiry, so that the knowledge can be said to be objective?" or (if the answer to the ontological question is that reality is socially constructed and there is no single 'real' version) "do each researcher and their research participants have their own version of that reality, so there is no single truth, only one that is known as a socially constructed reality?" (Illing and Carter 2018).

As indicated in the abstract of this chapter, there has been a shift toward greater methodological rigor in health professions education. This has come about, in part, due to a greater understanding of the variety of philosophical stances or paradigms that underpin and guide our research methodology in order to increase the quality and integrity of medical education research (Rees and Monrouxe 2010; Bunniss and Kelly 2010). Further, there is improved understanding of the importance of the way philosophical stances influence the knowledge that is constructed through the research and the methods and methodology used to derive that knowledge (Rees and Monrouxe 2010) Philosophical stances guide the way our research is conducted from the way one approaches the research, the methods used, and the way data is analysed and interpreted. For example, if you analyse your data using a thematic analysis approach from a post-positivist stance, the way you interpret your data will be different to if you adopt a constructivist approach to your research. In this way, considering and explaining your philosophical stance at the beginning of your project is of paramount importance (Braun and Clark 1996).

Broadly speaking, there are four main types of philosophical stances that we will discuss: positivism, post-positivism, constructivism, and critical theory. Each of these four stances have their own ontological and epistemological position. There has been much written about these perspectives, and it is beyond the scope of this chapter to go into them in depth—for those interested in learning more, there is a plethora of resources available to this end (for example; Crotty 2003). It is our aim to provide an overview of each type of philosophical stance and the ontology, epistemology and methods used within each, as an entry to these sorts of considerations. From a practical perspective, we will also consider the implications of adopting each stance for interested health professions education researchers. We will provide an example later in this chapter to illustrate the impact that taking different stances can make to the way in which research is conducted, what can be learned from it, and what recommendations we can draw from it for our own practice.

13.3.3 Positivism

Positivism is rooted in the work of the philosopher Auguste Comte (so-called 'classical positivism') and of an interdisciplinary group called the Vienna Circle ('logical positivism'). All of the other philosophical stances we will discuss agree that positivism should be rejected, though the generally accepted description of this position does not do justice to the views of actual positivists (Phillips 2000). Despite the existence of misinterpretations, we can identify the core ontological and epistemological claims of positivism that are rejected by other philosophical stances.

- The core *ontological claim* of positivism is that any claim to knowledge should be verifiable through sense experience.
- The corresponding *empirical claim* is that such experiential data provides an objective (intersubjective) foundation for scientific theories, which express connections between data using formal logical methods. This epistemological approach leaves no role for researchers to interpret their data.
- *Practical implications for researchers:* we can see that it is assumed that researchers will carry out their research in a vacuum, where there will not be any outside influences, and the researcher's prior knowledge and experience will not have an influence on the collecting and interpreting of data. Researchers look to prove or disprove a theory or hypothesis, data is deductive in nature and is very much in the realm of quantitative research (such as clinical trials, surveys, questionnaires). Findings often add to existing knowledge in the field being studied. Findings can be generalisable and research quality i.e., rigour, validity, and reliability are easily presented and shown. If we take the recent global pandemic of COVID-19 as an example, positivist research would be useful in helping to understand *what* was done both clinically and within health professions education (Chow et al. 2021).

13.3.4 Post-positivism

Post-positivism can be traced to the work of Karl Popper ([1959] 1992), who disagreed with the positivists' view that increasing amounts of empirical support made it more likely that a theory is true (i.e., that data 'confirms' a theory). Instead, Popper emphasized that, logically, it is impossible to prove a theory, but it is possible to disprove one by providing evidence that contradicts it. Kuhn, mentioned earlier, is also a foundational figure for post-positivist views. Building on Kuhn's idea of a paradigm, or worldview, post-positivists emphasize the distinction between reality and what we can know of it.

- The core *ontological claim* of post-positivism is critical realism. Critical realism distinguishes between the real world and the observable world, maintaining that the real world cannot be observed. What researchers investigate is a product of our experiences and perceptions of our observations. Researchers do not exist in a vacuum and are influenced by what is happening around them (Crossan 2003).
- In regard to *epistemology,* post-positivism adopts an objectivist approach, but, unlike positivism, where there is only right or wrong, post-positivists believe that data can be subject to a critical review. Indeed, it is assumed that research can never be totally objective, no matter how rigorously the research is carried out.
- *Practical implications for researchers:* whilst this method is still very much orientated toward the more traditionally scientific way of thinking using hypotheses and theories, it recognises that data are collected in the social world and, therefore, cannot be controlled as easily as in a laboratory setting, for example, as scientific experiments can be. Data are therefore subject to some 'controlled' influences.

Data can be collected through both quantitative (e.g., surveys, questionnaires) and qualitative (e.g., interviews, focus groups) collection methods and triangulation of data is usually used i.e., more than one type of data are used to help support a hypothesis. Quality assurance is still achieved through internal and external validity, reliability, and objectivity.

13.3.5 Constructivism

There are various types of Constructivism depending on your view. Whilst the distinction between constructivism and constructionism will be explained in Chapter 14, it is worth briefly paying heed to it here to avoid confusion between these two popular terms in the context of this chapter. The main distinction between constructivism and constructionism is explained by Schwandt (1994). Constructivism is understood by the individual mind, whereas in constructionism meaning is understood through a societal or cultural context. The main types of constructivism and constructionism are described by Gergen (2015) as:

- *Radical constructivism,* which comes from rationalist philosophy and concentrates on what an individual takes to be reality. In other words, this type of constructivism highlights the way in which one constructs reality through a systematic relationship to the external world around them.
- *Social constructivism,* which highlights that, while each individuals' mind constructs reality in its relationship to the world, this process is heavily influenced by social relationships.
- Social constructionism, which looks at the way self and the world are understood and influenced by power and social structures such as; the government, schools etc. (Gergen 2015).

Broadly speaking, and for the purpose of this chapter, constructivism is taken as the position that knowledge is not discovered but is socially constructed. Everything has a socially constructed meaning and is dependent on culture and societal values and experiences i.e., the way we see something even if it has a reality, it may have a different meaning or be perceived differently depending on how it is viewed by an individual. For example, death is a socially constructed concept. Whilst it is reality, it is perceived, understood, and explained differently by different individuals and societies. Constructivism recognises that there is no right or wrong answer to something, it is interpretation that gives us our answer.

- The *ontological claim* of constructivism i*s* either relativism i.e., there are different realities, which often are at odds with each other, or pluralism, in which different realities co-exist but are not seen as conflicting. Again, there are several types of relativism, but, for the purpose of this chapter, we adopt the above definition of relativism. It is believed that realities are socially constructed depending on individuals' experiences, values, and beliefs. Therefore, reality is subjective and

can change and be fluid, rather than be absolute or fixed. This is a very different theoretical perspective than positivism and post-positivism.

- In regard to the *epistemology* of constructivism, proponents of this stance maintain that there is no objective approach—researchers and the phenomena being studied cannot be separated. The researcher's job is to analyse the different interpretations of what is being said to achieve an understanding of what is happening.
- *Practical implications for researchers:* it is important for researchers to reflect on and understand their own experiences, culture, and values and consider how this impacts their research. Data are inductive and generally collected through qualitative data methods (e.g., semi-structured interviews, focus groups) and is concerned with explaining *'why'* something happens rather than 'what' is happening. Data are usually not generalisable as there are often small sample sizes or data are collected in one specific setting. Though data may not be generalisable, they may be transferable, however, to other contexts. Quality assurances are through trustworthiness, transferability, dependability, and conformability (Lincoln and Guba 1985).

13.3.6 Critical Theory

It is worth noting here that there is no one critical theory, but a collection of theories. Critical theory originated from the Frankfurt school (which concentrated on social oppression) but has been expanded and developed since (Chow et al. 2021) to encompass feminist (reflection that science and research is male dominated) and Marxist (conflict class struggles and a conflict between capital and labour markets and how these influence economics and society) perspectives. It is concerned with questioning the world of objective appearances to expose the ways in which social oppression took place, for example research looking at racial inequalities in the way black and white patients are treated (Chow et al. 2021). Central to critical theory is the belief that the *aim* of theorizing is to effect social change by addressing social oppression.

- In regard to the *ontology* of critical theory, though reality is often seen as objective, that reality is also conceptualised as subject to continual change. Such change may encompass changes through history which are influenced by culture, society, politics, economics, and gender. More recently, global pandemics such as the COVID-19 pandemic are additional forces of ontological change within critical theory approaches.
- The *epistemology* of critical theory is subjectivist and transactional. This approach assumes the researcher is unable to distance themselves from their prior experience, values, and knowledge i.e. that the researcher and the object that is under investigation are intrinsically linked in some way, which facilitates a continuously changing dynamic.
- *Practical implications for researchers:* similar to the constructivist stance, it is important that researchers reflect on their own experiences, values, and culture

to enable them to better understand and challenge findings with participants. Research within this paradigm tends to be iterative, using more participatory methodologies such as case studies, focus groups and observations (Bunniss and Kelly 2010). Both qualitative and quantitative methods are used to collect data. Similarly to the constructivist approach, quality assurances are through trustworthiness, transferability, dependability and conformability (Lincoln and Guba 1985). If we again take the global pandemic of COVID-19 as an example, critical theorists could study this pandemic through the lens of social inequality, racial inequality or political power (Chow et al. 2021).

13.4 Where Are We Now and Where Do We Need to Be?

We must ensure our research has strong theoretical frameworks and that a clear purpose is highlighted (Bunniss and Kelly 2010; Zaidi and Larsen 2018). Without such clarity and rigour, the negative perception towards health professions education may continue. Some have argued that health professions education research is (and should be) constructed as a social science (Monrouxe and Rees 2009) and we, therefore, must engage critically with the questions of research philosophy that are central to that tradition (Lingard 2007). Due to the complexity of health professions education, often defined by contextual factors, many writers have challenged the dominant positivist paradigm within the field, and the field's focus on experimental methods (Kuper et al. 2007; Dornan et al. 2008). In this way, there is tension between defining legitimacy within the previously considered research perspectives and health professions research in operation (Bunniss and Kelly 2010).

Qualitative research still raises concerns for some, despite its ability to resolve "real-world" problems (Sandelowski 2004). One key reason that qualitative research can be perceived as not useful is that the results of multiple qualitative studies are not generally integrated, synthesized, or otherwise put together, analogous to the use of meta-analysis in quantitative research. Qualitative research findings contain information about the subtleties and complexities of human responses to issues we are concerned with. However, for qualitative research findings to matter, they must be presented in a form that is assimilable into the "personal modes of knowing... valuing" (Noblit 1984, 95) and/or doing of potential users, including researchers and practitioners. After all, bridging the gap between research and practice (both clinical and educational) is key, with the aim to ultimately benefit patients (Kajamma et al. 2019). Kajamma et al. (2019) illustrate this well through their presentation of action research and The Change Laboratory methods; two approaches that involve qualitative research that led to a change in practice; mixing social action and scientific inquiry. These approaches help to answer tricky 'why' and 'how' questions, which may further help to unlock deep insights to enhance learning and patient care.

Empirical research in the field continues to focus on methodology that describes the techniques used for data collection and analysis. Describing the tools we use in a piece of research in this way is not the essence of the qualitative approach—we

join with Lingard (2007) in suggesting that more of a focus on the 'orientation' of qualitative research is necessary:

> Asking questions such as 'What kind of knowledge are the researchers setting out to make? What are their views on knowledge, their epistemology? Are they conducting the study from an ethnographic, a critical theory, or a case study approach? These dimensions matter much more than the methodological tools because they shape the way the research question is asked. (S129)

The philosophical stance within which a study is situated will guide how you conduct the research and, even more importantly, how you interpret your outcomes and results (Bordage 2009).

Ultimately, the message here is that, whilst the research we are doing within health professions education is important and a tight-knit community has been built, it is now time to focus *even more* on extending this research to a wider scope. In doing so, findings within our field will have more influence across other fields of research. To do this, it is essential that we are able to articulate our research assumptions in order to allow others to critically consider the nature of our knowledge claims within our discipline (Bunniss and Kelly 2010; Johnston et al. 2018). Academic research stems from a philosophical tradition of systematic knowledge development; any knowledge claim is only defensible within a wider set of assumptions about the nature of reality (Denzin and Lincoln 2000).

13.5 Complexity of Choosing and Explaining Our Philosophical Perspective: An Example

Whilst we have illustrated differing paradigms or philosophical stances within this chapter, it is important to note that not all research approaches fit 'neatly' within one paradigm or another. And that can be hard for us to fully grasp. We often like to be guided by approaches that fit neatly within a box. There are some perspectives that may fall between the ones detailed previously. In order to highlight the complexity of the issue, we will work through a realist example within this section. We have purposely chosen realism due to the fact it falls perfectly between differing paradigms.

Firstly then, let's start with a bit of background to the realist approach. Realism is a post-positivist school of philosophy, sitting between positivism and constructivism. In this case, it is not a simple matter of choosing one paradigm or philosophical stance over the other. Realism assumes that social systems and structures are 'real' and that individuals respond differently to different interventions in different circumstances (Kehoe 2017). This is the place in which the example below sits, crossing over the two paradigms and, therefore, utilising the power and strengths of both.

The key feature of realism is its stress on the 'mechanics of explanation' that can lead to a 'progressive body of scientific knowledge' (Pawson and Tilly 1997, 55). This offers explanatory power when dealing with complex interventions. Wong et al.

(2012) note that complex interventions do not act in a linear fashion, are reliant on the people carrying out the intervention, and are highly dependent on the context in which they take place. Realists would direct us to think in productive ways about complex problems and create positive developments in the world around us (Kehoe 2017). Yet, how do we get to our conclusions about this? Figure 13.1 illustrates an example of how researchers decide, illustrate, and conduct research through considerations of their philosophical stance. To concord with our realist example, Fig. 13.1 concerns a realist body of research.

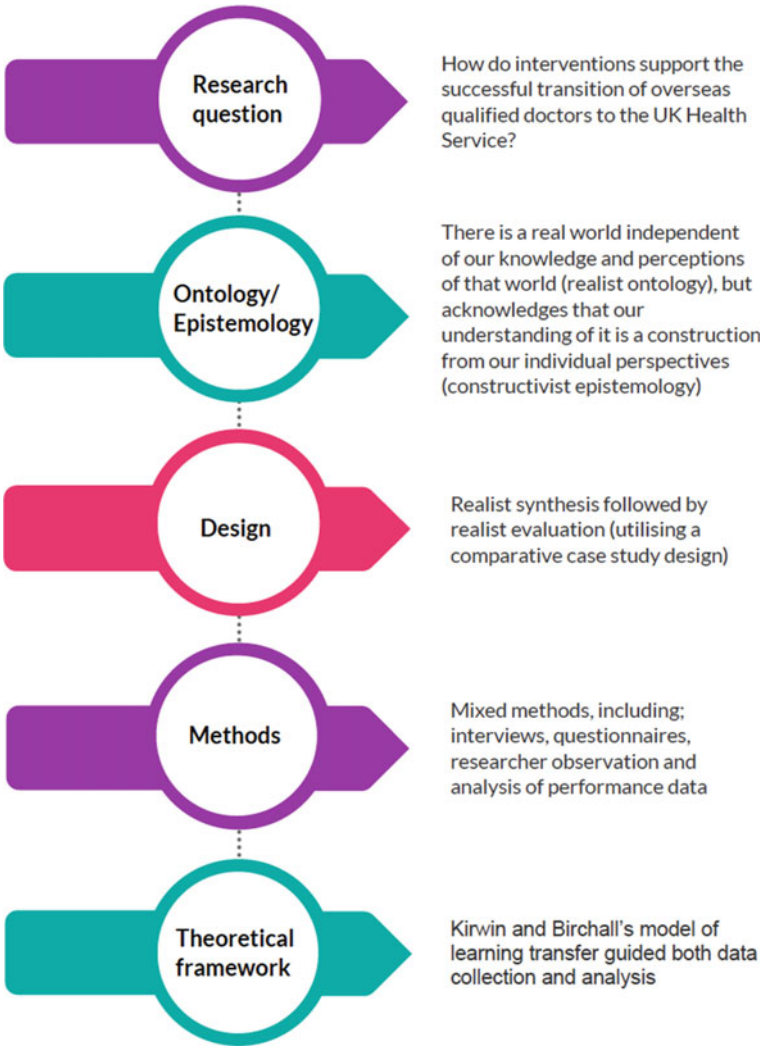

Fig. 13.1 Example realist research study conducted by Kehoe (2017), including theory by Kirwin and Birchall (2006)

Within the example from Fig. 13.1, theory-driven synthesis and evaluation ensured that the overall research aims, and objectives, were met; explaining the contingencies as to how interventions support overseas qualified doctors in making a successful transition to the UK workplace and highlighting barriers to a successful transition. The evaluation sought to explain change brought about by particular interventions by referring to those individuals who act and change (or not) in a situation under specific conditions and under the influence of external events (including the intervention itself) (Kehoe 2017). Exploration of the social reality that influences how the intervention is implemented and how actors respond to it (or not) was sought.

The theory (or grand theory) chosen in the example above (Kirwin and Birchall's work [2006]) was selected to guide the research because it encompassed many elements of overseas medical graduates' learning and transitioning in a single model. Interventions developed for this group of health professionals are often complex, therefore utilizing this model enabled a better understanding of how interventions could help adjustment for overseas graduates to working within the National Health Service (NHS). The levels in the model helped to both understand and analyse the influence of environmental, training and individual characteristics. Ultimately, the applied nature of the model aided in understanding the contextual factors that are at work when transferring learning into practice, as well as highlighting potential mechanisms which were essential for the realist approach.

A synthesis of the mixed methods findings, including literature review, observations, performance data and 123 interviews, illustrated that three key contextual levels; organisational, training and individual, will likely impact on the adjustment of overseas doctors (including performance, retention, career progression and well-being) (Kehoe 2017). One of the main outcomes was a transferable, theoretical explanation of how interventions can successfully support the transition of overseas medical graduates to the NHS.

Ultimately, the way in which this piece of research was developed allowed the generation of valid explanations as to why and how the observed results of the interventions being evaluated were achieved (feeding into theory refinement), explaining the 'black box' that is often not addressed in outcome-focused approaches (Wong et al. 2012). The philosophical stance of the author was important in ensuring they achieved this understanding about how interventions could be developed and improved for future implementation.

Whilst the realist approach chosen for this study was entirely the perfect fit in the author's eyes as it enabled rich and detailed exploration of the 'hows' and 'whys' and allowed creativity in the development of the programme theory, it was, at times, difficult to navigate. There was no 'clear path' to follow as it was dependent on researcher perspective and ability to build a story from the data. What the author constructed may have been different to what another researcher may have developed (with possibly a different philosophical perspective), and that knowledge can sit uneasily, at times. Though the developed programme theory was driven by study data, this may have differed with an alternative researchers' differing interpretation.

Based on the experience and reflections of those involved in the above project, we have developed five take-home messages specifically regarding the use of an

Table 13.1 Realist research take home messages

Combining the strengths of both qualitative and quantitative methodologies, and of philosophical stances, can help researchers to identify and triangulate rich evidence that will produce a coherent and plausible explanation of the contents of the 'black box' (Wong et al. 2012)
Exploring more than outcomes and contexts, but causation, is crucial for optimising development, implementation, and effectiveness, particularly if exploring educational training or interventions
Much of the success of this perspective (as well as others) is that it relies on achieving immersion (Wong et al. 2012) i.e., spending enough time in the study to really know what is going on. In this way, researchers should permit enough time in their project timelines to immerse themselves fully amongst their data
As interpretation matters in this approach, researchers should think reflexively. To do so, they should develop theories iteratively as collected data is analysed, look for alternative explanations during their analysis, and be able to defend their interpretations (Wong et al. 2012)
Dependability as a marker of quality can be assured here through transparency and reliability. To do so, researchers must ensure full documentation of their approach, and that the research pathway they have followed is sufficiently illustrated in any written summaries of their research. The realist approach also holds much credibility and conformability through respondent validation and ongoing discussions to check the theory (stakeholders, interviews, etc.) (Walsh 2013)—this may be something researchers wish to consider

approach that 'falls between the lines' of the four common philosophical stances we have described in this chapter. We have developed these reflections as there exists less guidance on philosophical considerations within this approach than within more widely used and long-standing traditions (e.g., positivism, constructivism). Our realist research take home messages can be viewed in Table 13.1.

13.6 Conclusion

All researchers must be able to think about and engage in the areas that we have discussed throughout this chapter, focusing on ontological and particularly epistemological discussions about the nature of the knowledge that health professions education research seeks to create (Bunniss and Kelly 2010). Developing an increased awareness of the paradigms in use within the field is important because we need to demonstrate that significant decisions regarding the provision of medical education and health care are based on a critical understanding of the nature of knowledge itself. Articulating these underlying assumptions is central to the research task if we are to be able to critically engage with the findings. Research methodology is not simply about data collection strategies (methods), but, more importantly, it is about the philosophical beliefs that determine the nature of the research design.

The quality of research is defined by the integrity and transparency of the research philosophy and methods, rather than the superiority of any one paradigm. Despite the chosen philosophical stance, there will still be useful and practical implications for the

Table 13.2 Practice points

1	All researchers should consider the ontological and epistemological assumptions or positions they adopt when undertaking health professions education research
2	When writing up research for publication or dissemination in some way, researchers should detail their philosophical assumptions regarding their research. This will allow other researchers, and those within other academic fields, to consider the applicability and relevance of their findings to their own contexts
3	Researchers and educators must be careful not to confuse methods and methodology and appreciate that central to the question of methodological selection are questions concerning philosophical orientation
4	Researchers and educators should be careful not to engage in paradigmatic snobbery or rivalry. The quality of research is defined by the integrity and transparency of the research philosophy and methods, rather than the superiority of any one paradigm
5	As a community, we must challenge negativity towards the field from other disciplines by banding together and following necessary the guidelines underpinned by the philosophy of science outlined in this chapter to increase the perceived rigour of the field

findings of a study. Where there is negativity towards the chosen stance, this is often a conflict of research assumptions. As a community, we can actively seek to improve any negativity towards the field by ensuring we follow the necessary guidelines underpinned by the philosophy of science in any research that we undertake (Table 13.2).

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Chapter 14
Tensions Between Individualism and Holism: A Philosophy of Social Science Perspective

Paul Crampton and Jamie Buckland

14.1 Introduction: Health Professions Education as a Social Science

Health professions education (HPE) as a disciplinary field has emerged from a plurality of influences. If we were feeling controversial, we could describe it as being a bastard of a subject. It is neither one thing or the other, with shifting influences and boundaries through time and space. In effect, it is an interdisciplinary field, where the discipline's roots come from a myriad of medical sciences, chemistry, biology, psychology, social sciences, education, business, linguistics, health economics, and many more. Nonetheless, from these tentative states has emerged a wealth of exceptional research insight that draws on the far corners of knowledge boundaries with the purpose of bringing clarity to unanswered questions and focusing on the '*why*' as well as '*what*' (Cook et al. 2008).

Yet, for many scholars and educators, the roots of HPE remain deeply intertwined with clinical medicine. The makeup of practitioners are chiefly those who have experienced 'hard science' education in a structured format, where knowledge testing has been the bedrock of demonstrating competence. This format has largely followed suit into the educational research undertaken, with the gold standard 'randomized controlled trial' still being seen as the optimal way in which to conduct medical education research (Cook and Beckman 2010). The favouring of controlling factors and minimizing unpredictability largely remains in key metrics when judging research in the field. Similarly, performance indicators have favoured quantitative reporting of

P. Crampton (✉)
Health Professions Education Unit, Hull York Medical School, University of York, York, UK
e-mail: paul.crampton@hyms.ac.uk

J. Buckland
Department of Philosophy, University of York, York, UK
e-mail: jamie.buckland@york.ac.uk

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impact factors, number of citations, and amount of grant funding captured. Yet collective scholarship environments which protect research time have been recognised for how they can foster more meaningful, rigorous research (Ajjwai et al. 2018).

As described in Chapter 13, only in recent years has HPE begun to see a greater grasp of multiple ways to view and assume ontology, with far-reaching consequences into methodological approaches (Monrouxe and Rees 2009). This chapter explores HPE through a social science lens to consider the differences between individual and team education and research in the field. The concept here of 'social science' broadly refers to all systematic empirical investigation into the activities of human beings, with a special interest in those things we do together, as part of larger social groups (Risjord 2014). The acknowledgement of how humans interact, make meaning, and forge new understandings is catered for within social science positionings. To take such a stance opens up the possibility of potential multiple subjective ontologies where truth is less the key attribute, but more a factor in which ways understandings come to be. Professionalism, empathy, and identity development enquiry are just some of the ways in which social science positionings can foster greater understanding of educational processes (Swick et al. 1999; Pedersen 2010). Picking up the gauntlet, we now expand on conceptualising HPE as a social science by focusing on the differences between individual and team approaches (Monrouxe and Rees 2009).

14.2 Workplace-Based Learning: Case Studies

A vivid form of HPE which aptly demonstrates the need for social science understandings is that of clinical placement experiences in healthcare settings, a form of workplace-based learning. A large component of HPE courses occur in clinical workplace settings, outside of more controlled university education environments. This creates complexity in how learning occurs and is researched, how educator guidance is structured, and how learning is ultimately assessed. The unpredictable nature of how a workplace operates and its association to education is impacted by numerous interrelated factors such as the individuals, teams, regulators, and systems which may facilitate and/or hinder learning.

Workplace based learning as a social, theoretical, and methodological construct is complex, as are the environments widely catalogued through a mixture of lenses spanning cognitivism, interpretivism, and anti-positivism (Dornan et al. 2007; Teunissen 2015). Although these approaches harbour inherent assumptions, there is the often-neglected disciplinary stance in which philosophical understandings can glean further insight regarding ontology, axiology, and methodology. These are explored in further detail within Chapters 10 and 12 of this book.

For educators and researchers, cultural shifts in which philosophical positions are brought to the forefront of awareness are needed to help develop other ways to teach, assess, and conceptualise learning. In reference to scholarship, drawing explicitly on philosophical debates in HPE is relatively under-developed, with recent papers beginning to show exceptional promise for the ways in which they may shape

refreshing understandings of longstanding approaches to inform practice for the benefits of learners, educators, and, ultimately, patients (Veen et al. 2020; Laughey et al. 2020).

To begin to distil the issues of how differing conceptualisations of individuals and teams may have alternative implications for HPE, let us first look at the constituent parts critical to learning through an example (Case Study 1). Throughout the remainder of this chapter, we provide examples which refer back to this case. Within clinical placements there are many transient groups, often changing on a day-by-day basis with multiple roles, actions, and states. Considerations of team effectiveness in this environment are largely neglected within HPE, with the fallout being monumental for individuals in terms of lost resources, enabling negative behaviour through lack of challenge, and triggering processes which further reinforce inequities such as lack of fairness. For example, the incidence of bullying, burnout, and lower psychological wellbeing are sadly well documented with many junior doctors leaving the profession as their professional education has not prepared them suitably (Carter et al. 2013).

Case Study 1: The Labour Ward: Student Learning Versus Healthcare Delivery Team

The labour ward in a busy district hospital is a hotbed of activity on a daily basis, with any number of healthcare professionals working together to provide patient care. A dual purpose is to provide education for healthcare students at any given time, including students from medicine, midwifery, and nursing. The students may belong to different undergraduate schools, yet when they arrive on the ward, there is a shared purpose. Various levels of learning spanning undergraduate to postgraduate interns may also be part of the environment. At times, there are new and inexperienced learners who then flourish or struggle before leaving and being replaced by further cohorts. The staffing team, similarly, can experience turnover in certain roles but, generally, is more stable in its makeup. The environment may experience acute care, at times, in which teams must work cooperatively. Herein presents great pressures as there is limited scope for error and an increased risk of high workload, poor communication, and hierarchical power between healthcare professions. The environment is monitored by quality standards judging aspects of how care is delivered to maintain patient safety, excellent education, and continuing professional development. If situations arise where levels of care are compromised, the environment may be unpicked for the ways in which it may facilitate such instances to occur.

Informed by the work of Palermo et al. (2014), Case Study 2 focuses on the assessment of competence for health professionals, offering an example which considers nutrition and dietetics trainees in the workplace. Regulators often mandate that healthcare professionals must satisfy workplace-based assessments at a postgraduate level to fulfil training aims. Typically, workplace-based assessments will look at

how a trainee is performing, any strengths and weaknesses in their work, and areas for improvement. Similarly to Case Study 1, the implications of the ongoing activity of the workplace and the ways in which individuals are conceptualised within education may impact on the feasible development of learners and constructions of how to educate and research relevant experiences. As with Case Study 1, we will draw on Case Study 2 to demonstrate how our discussion and analysis of the individualism versus holism debate is relevant to the field of health professions education.

Case Study 2: Workplace-Based Learning: Student Progress Versus Patient Delivery

As a nutrition and dietetics trainee develops their experience, they are required to complete workplace-based assessments. However, within training there are challenges in how the workplace environment can effectively allow trainees to learn, and how effectively educators can assess their work according to required standards. There may be a lack of senior experienced educators which leads to novice educators being responsible for workplace-based assessments, presenting yet more noise in guiding learning. Factors relating to the workplace, such as services provided and the typical workload of staff, as well as working relationships with other healthcare professions may all impact in some way on what is achievable. Further, workload demand can limit the time available for effective assessments of trainees. The lack of case-mix presents limited opportunities for an individual to be able to observe and interact with the learning experiences needed in order to pass WPBA. There are also barriers around the different expectations about what is expected of students, held by colleagues from different healthcare professions, supervisors, peers, and individuals themselves.

Throughout the remainder of this chapter, we provide examples which refer back to the above cases. The cases provide a context for the individualism and holism debate which draw on different features which interact within workplace-based learning situations to highlight the overlaps and boundaries between how individuals are considered separate, interlinked, or as one within a collective. Where relevant, practice points are also indicated throughout, though they are also captured in full at the end of the chapter.

14.3 Individualism and Holism in the Philosophy of Social Sciences

The dispute between individualism and holism in the philosophy of social sciences can be divided into two distinct (but related) categories:

- **The Ontological Issue:** What is the ontological status of social phenomena and, as part of this, their relationship to individuals?
- **The Methodological Issue:** To what extent may, and should, social scientific explanations focus on individuals and social phenomena respectively?
  (Zahle and Collin 2014)

The ontological issue is perhaps best explicated from within the context of *reductionism* (Risjord 2014). Broadly speaking, the social sciences investigate two kinds of social phenomena: individual agents (such as students within HPE) on the one hand; and the social 'objects' (such as universities and hospitals) on the other. These positions can be referred to as ontological individualism and ontological holism, respectively.

For an ontological *individualist*, there is nothing over and above social phenomena than distinct individuals with their beliefs, desires, values, professional competencies, etc. For the ontological individualist, the ontological status of social phenomena can be reduced to the individuals that make it up (Mill [1872] 1987). The learning of individuals throughout HPE could perhaps be replicated irrespective of the social institutions in which their learning occurs. The individual has the ability to be able to limit influences and mediate social interactions without influencing potential behavioural and cognitive domains. Individuals traverse various social and organisational contexts coming into social groups but notwithstanding that such phenomena be characterised by its various entities.

Whereas, for an ontological *holist*, certain social phenomena (social objects) exist over and above (or transcend) the collection of individuals that make it up. Durkheim, for example, maintained that social phenomena and the acts of individual agents within a social setting can only be *explained* by invoking the existence of certain social facts (Durkheim [1895] 1938). More recently, however, it has been argued that an 'agency criterion' is what best answers the question of what it takes for a social phenomenon to exist (*sui generis*) over and above the individuals that compose it. Such an agency criterion holds that social phenomena such as universities and hospitals exist:

> insofar as they qualify as group agents that have attitudes supervenient upon the attitudes of individuals. (Zahle and Collin 2014, 3; List and Pettit 2011)

To this extent, then, the ontological issue is connected to a further explanatory issue or, rather, the *methodological issue*. For ontological holists such as Durkheim, there are social-level explanations of an agent's actions within a social setting (methodological (or explanatory) holism). For ontological individualists such as Mill, explanations in the social sciences make reference only to individual actions, and social phenomena are explained as the outcome of individual choices and actions (methodological (or explanatory) individualism). We can illuminate the differences between methodological individualists, and methodological holists, using an example. In Case Study 1, we considered how workplace-based learning environments are monitored by quality standards to maintain patient safety and high-quality education. It is this we shall build on to illuminate the differences between methodological individualism

and holism. You work in a hospital that has recently been found by the body that evaluates its quality (in the United Kingdom, for example, this is the Care Quality Commission or CQC) to be failing to meet minimum standards. Methodological holists might focus on how a recent economic depression which reduced the funding your hospital received led to the hospital failing its inspection. Methodological individualists, on the other hand, would be dissatisfied with such an explanation—at least, such an explanation in and of itself. Their focus would be on the behaviours, beliefs, attitudes, and actions of individuals that led to the hospital failing to pass inspection. Though we have described these positions as existing in tension with one another (and they often do), they need not be incompatible. In this example, methodological individualists could add depth—micro-level foundations—to the holist's macro-level explanation of the cause of the failed hospital inspection by exploring how individuals' behaviours, beliefs, attitudes, and actions *in response* to the economic depression and subsequent lack of funding culminated in a failing grade.

Whereas we have principally focused on the classification system that divides the individualism versus holism debate into ontological and methodological positions, there are other systems of classification. Though it is beyond the scope of this chapter to detail these in full, we wish to draw your attention to Risjord's (2014) tripartite classificatory system, that divides the debate not only into ontological and methodological concerns, but also considers the differences between individualists and holists in reference to theory. We believe this addition to the ontological and methodological positions we have already outlined has particular relevance to our field. Individualists in Risjord's system hold that social science theories can be derived from psychological theories, while holists hold that social scientific theories are logically independent of lower-level theories. For an interdisciplinary field such as health professions education, this system offers an interesting lens through which researchers could view psychological and sociological theory, that the field has historically heavily drawn upon. Risjord's additional theoretical domain of the individualism versus holism debate is no more apparent than within scholarship concerning professional identity development in the field (for a more thorough discussion of professional identity, see Chapters 3 and 17). Professional identity can be conceptualised from a multitude of theoretical positions within health professions education research (Sawatsky et al. 2020; Brown et al. 2021)—some scholars utilise psychological theories (which focus primarily on the role of the individual in identity development), and others utilise sociological theories (which focus primarily on the role of interactions and the social world). In addition, there are those that suggest both explanations are necessary—psychological and sociological ones—to adequately conceptualise identity formation in the health professions (Jarvis-Selinger et al. 2012), implying an individualist theoretical position where social science theories must be underpinned by psychological understandings—in this case, of identity. Perhaps unsurprisingly, there are those that disagree and utilise solely social science theories to offer full understanding of identity development in different contexts (theoretical holists) (Monrouxe and Rees 2015).

Now that we have considered the various domains in which individualists and holists may have views that differ (ontological domain, methodological domain,

and Risjord's [2014] theoretical domain), it is important to examine what impact this diversity of views and positions might have on health professions education. Building on these understandings, we suggest that there is an invitation for health professions education programme directors to openly address the ways in which education is currently situated within current approaches to reveal the ways in which education environments are being constructed (Practice Point 1).

To return to Case Study 1 and the quality standards we have previously discussed, standards and reports issued by those that monitor healthcare organisations (again, the Care Quality Commission or CQC in the UK) could be viewed to explain institutions and placement providers in which HPE may be more effective and optimal. Here, programme directors could examine these documents for both methodological individualist and methodological holist explanations for why an environment either leads to a positive or negative experience for their trainees. Further, specific education standards within healthcare providers monitored by regulators (e.g., the General Medical Council, also in the UK) might provide further explanatory power as to learning experiences afforded within social settings. The cultural approaches in maintaining and meeting various standards comes with the wider application of instilling excellent education frameworks through supervision, training, and assessment. The interplay of how various parts of social norms interact within the healthcare system provide both the opportunity for individuals to develop learning, but also for how learning can be transformed through its occurrence in social level situations.

Strict methodological (or explanatory) holists could argue that strong methodological individualism demands the impossible. We have considered the two approaches as complementary, as adding depth to one another, in our example of a failing hospital in a previous section of this chapter. However, strong methodological individualist positions do exist, which we suggest may be less suitable for exploring workplace-based learning environments. Methodological individualists believe that the causal powers of social-level entities are carried by the agents of those entities, just as the causal power of a clock to chime "cuckoo" is carried by its particular mechanism. A social-level predicate like "orderliness" will be instantiated in each neighbourhood by a different set of activities. For example, regarding implications of Case Study 1, within one nursing school, student punctuality may be the problem, but, in another, it might be the poor teaching experience. Some nursing schools may have strategic requirements for educator quality, others may rely on the passion of those who teach. Multiple realisability means that each individual-level explanation would have to be different. Individualists contend that interventions (to increase, say "orderliness") must target individuals, since only they have causal powers. Explanatory or methodological holism, meanwhile, would respond to this argument—for holists, without the generalising power of terms like "orderliness", we would not know which set of individual actions to intervene upon. Therefore, our capacity to implement social policy depends on a holistic approach. As such, for educators we suggest a need to consciously moderate the impact of quality standards and service delivery, whilst having expectations of learners appropriate to the context (Practice Point 2).

Table 14.1 An overview of the ontological, methodological, and theoretical positions adopted by individualists and holists

Position in the individualism versus holism debate	Description
Ontological individualism	Facts about individuals determine social facts—in other words, reality is, and therefore social objects are, made up of individuals. Focus of study would usually be individual agents: e.g., students in health professions education
Ontological holism	This position claims that social objects or entities are independent and autonomous—i.e., they are not simply derived from the individuals that partake in them. Focus of study is usually social objects in their entirety e.g., a higher education institution
Methodological or explanatory individualism	Social phenomena must be explained by showing how they result from individual actions
Methodological or explanatory holism	This position maintains explanations that invoke social phenomena (e.g., social structures, cultures, institutions) should be the focus of study within the social sciences. It is these social phenomena that offer explanations for the things that happen in the world
Theoretical individualism	Social science theories can be derived from psychological theories
Theoretical holism	Social science theories are logically independent of psychological or individualistic theories

In Table 14.1, we offer an overview of the various ontological, methodological, and theoretical positions outlined in this section to represent the individualism versus holism debate as applied to contemporary issues in health professions education.

14.4 Differences Between Conceptualising Students Within HPE as Individuals and Students as Part of Interprofessional Teams

The philosophy of social sciences has various schools of thought in which theoretical foundations may privilege particular approaches to understanding and conceptualising individuals' and social dynamic experiences of learning. Within this section, we discuss constructivism and constructionism as two distinct approaches to provide illustrative examples. The awareness of philosophical issues (such as metaphysical/ontological; axiological; epistemological) and the ability to critically evaluate the philosophical commitments of a theory or methodology can significantly sharpen

social scientific inquiry. The debates around how to recognise and develop competence may be factored within such foundations as they may privilege the individual over the group in how education is curated, designed, and delivered.

The relevance of interprofessional teamwork within HPE is increasingly tested, as teams and individuals transition into new roles and spend too little time to bond or form meaningful connections. Transitions occur in roles within teams, departments, and even within organisations. The risk to patient care has, unfortunately, been demonstrated where ineffective teams have been implicated in lapses in patient safety standards (Francis 2013). Yet, the actions and responsibility of such teams may not be seen as distinct, as hierarchy and order play a pivotal role in how the team functions. Can a student be effective and still learn in an underperforming team? Hierarchy and order are key features in which teams may be held to account, but individuals will have little impact, especially students and those at the fringes of collective activity.

As illustrated in Case Study 2, currently, educational institutions are focusing on how individuals may learn and progress *irrespective* of the teams in which they are placed throughout their learning journeys. Within healthcare systems, there is little accountability for how education may differ, which is, perhaps, restricted by regulatory processes such as meeting set curriculum standards or core competencies. The individual, therefore, must navigate their own unique barriers and enablers to ensure they meet required parameters. Educational settings and environments are there to facilitate such processes, yet they can often inhibit or, even, ruin such pursuits. Here the case for recognising wider group contexts is apparent, as the social environment may play a pivotal role in education. Similarly, the unique nature of individuals is to be embraced through inclusive curricula accounting for differences in learners.

As introduced in Chapter 10, social construction*ist* approaches are characterised by attention to the ways in which contexts and social interactions interact with individuals through language, actions, and behaviours to elicit different constructions of the world (Rees et al. 2020). This approach is distinct from social constructiv*ism* which is more akin to cognitive and individualistic approaches, where knowledge is how a learner may interpret a situation (for a different interpretation of constructionism that frames the approach as, still, ultimately an individualistic approach, see Chapter 3). The way in which knowledge is created in social meaning-making instances is influenced by co-constructions with others with whom one interacts within a social context. There are contrasts with pre-set and guided learning outcomes which leads to difficulties in how assessments may then occur. The individuals become less influential in how learning occurs, as, through engagement in co-construction, debate, and the formation of collective understandings, new forms of knowledge are elevated.

Through the example in Case Study 1, multiple implications can be inferred—for instance, that interprofessional teams are not currently seen, or assessed, as one whole (Practice point 3). Multi-disciplinary teams are made up of multi-professions which combine to make decisions and carry out patient care at the interface of education and service provision. Yet, the HPE field often continues a lack of genuine interprofessional education across the world, as governing procedures have squeezed the availability of learning spaces in which cross-fertilisation can flourish. Each

profession often has their own specific set of learning outcomes, which makes collective approaches fruitless in how they effectively assess students at a given time, thereby omitting social level meaning-making. Mainstream institutional and regulatory changes would be needed to enable a radical approach in which team apprenticeship type models are the norm, that break down disciplinary hierarchies.

To consider how scholars, educators, and researchers can address such imbalances, in the following section we look more closely at the philosophical debates surrounding individualism and holism as applied to the case studies outlined earlier in our chapter. Constructionism is more akin to holism approaches, whereby the social level environment is privileged in how learning occurs, whereas constructivism relates more closely to individualism principles in how knowledge is developed, assessed, and conceptualised.

14.5 Social Phenomena, Intentions, and Collective Action

The ontology of the social world focuses on the ontological status of social phenomena such as universities and healthcare settings. However in Case Study 1 and Case Study 2, from within the context of HPE, the relevant categories of social phenomena are much broader and complex, including the type of care provided by specific departments (e.g., physiotherapy, community practice, labour), multidisciplinary and interprofessional teams (e.g., nursing, dietetics, midwifery), governance and adherence to standards (e.g., healthcare regulators), and the interaction of where service provision meets education (e.g., clinical and educational supervisors, trainees, junior doctors, undergraduate students).

The agency criterion holds that the social phenomena at the heart of HPE exist insofar as they qualify as group agents that have attitudes supervenient upon the attitudes of individuals. Certainly, everyday talk tends to represent collections of individual agents as a kind of unity capable of performing in the same manner as individuals do, but is this talk merely metaphorical (as the ontological individualist maintains)? Or should it be understood literally (as the ontological holist maintains)? When a clinical interprofessional healthcare team saves the life of a patient, or performs a complex surgical procedure, it seems clear that *the team* has done something that no individual can do alone, but is it sensible to maintain (say) the surgical ward exists insofar as it qualifies as a group agent with an attitude supervenient upon the attitudes of the individual agents that compose it? In Case Study 2, the difficulties in assessing individuals' competence within workplace-based assessment challenges whether and how educators should hold individuals accountable for their progress, or whether the team as a whole should be the unit of measurement (Practice Point 4).

It is not our purpose to address these complex questions, but, rather, to draw attention to the fact that once focus shifts from the ontological status of social entities—such as clinical teams—to social actions—such as team performance—this allows space for exploring how collective, joint, or group action can be understood, and the

ramifications this might have concerning the ways in which individuals and/or teams are trained, assessed, developed, and researched within HPE. The effectiveness of the team within the health service is very rarely accounted for within an individual students' learning journey, i.e., there is no difference made in where and how students train; it is just luck of the draw in whether the department is functioning at a high level and can support learning in addition to service delivery.

In Case Study 1, the level of activity challenges the effectiveness of the team providing education, in part, due to the amount of patient care provided. How, then, how have philosophers thought about collective, joint, or group action? And what impact might this have on how HPE is conceptualised and researched?

The ontological holist treats groups or teams as a special kind of agent. Given this idea, when we speak of a surgical team performing a successful operation, we are literally referring to a unique entity (or collective agent) constituted by the successful performance of the operation.

A thoroughgoing ontological individualist, on the other hand, rejects the idea that groups or teams are a special kind of agent along with the very idea of group agency. Agency is something only individuals possess (for a more thorough handling of agency, see Chapter 7; for discussions of non-human agency, see Chapters 12 and 16). When a particular member of a clinical team maintains that *'We intend to save the patient's life'*, it simply means that *that* particular member intends to save the patient's life (Bratman 1997). This impacts group assessment to the extent that individuals can maintain competency—after all, it is odd to maintain that one could have an intention to do something that is beyond their control. Moreover, when a clinical team fails to meet the governance standards of care required it, perhaps, does not make sense to maintain that the team has failed in some sense. The level of accountability within a healthcare team could be seen as the makeup of the performing individuals, be it their profession, competence, or skill.

Nevertheless, there are difficulties for the throughgoing individualist to the extent that the joint or collective action of the healthcare team performing an interprofessional teamwork action is something that literally cannot be done by any single member of the team. For this reason, philosophers such as John Searle (1995) and Raimo Tuomela (2002) maintain that the individual team members engaged in collective action form a special kind of 'we-intention'. So, when the healthcare team intends to save the life of the patient, each member of the team has we-mode intention to the extent that each member intends that each member will carry out their role to the best of their ability, i.e., joint action is the coordinated action of individuals. Granted, each member of the team has their own individual intentions related to their specific roles, e.g., the anaesthetist might maintain that the surgical team intends to save the life of a patient by means her anesthetising the patient, but this doesn't undermine we-intention (Practice point 5).

A further related point is to note the connection between we-mode intentions and the subject of team reasoning. HPE students approach patient care as members of a team, i.e., issues surrounding patient care are taken to be issues for *the team*, as opposed to issues for the individual members of the team, per se. Consequently, we-mode intentions have a different content to that of I-mode intentions associated with

individual intentions. In the case of an I-mode intention, an individual will justify their action based on responsiveness to reasons that reflect their idiosyncratic aims. By contrast, when an individual forms a we-mode intention, they intend to act *as a* member of the team, and are responsive to reasons grounded in the aims of the group. The group have collectively accepted the goal of saving the life of the patient, and that is a shared reason for each of the group members to act. Each member of the clinical team shares *the same* reason for action, and when individual members act for that reason, they are acting as a member of the group.

14.6 Conclusion

Taking a philosophy of social science perspective enables educators and researchers to develop insight into the ways in which HPE may privilege specific aspects of learning to the detriment of others. The individual versus holism debate contests departing features within such approaches and may help educators to see the relevance of conceptualising learners and interprofessional teams in different ways. Within the chapter we focus on workplace based clinical placement experiences to illustrate such tensions regarding learning and assessment in HPE. The ways in which students and teams are educated, assessed, and conceptualised brings about challenges for educators and researchers in how best to facilitate learning within HPE. The individual and holism debate faces a tension in the clinical workplace with regard to the agency criterion and collective agents in clinical placement experiences. Applying this debate to HPE we should ask how and whether individuals should be considered as a collective within education, or whether the focus of education should remain as it currently resides, with a principal focus on the education, development, and assessment of each individual. The implications for how these constituent parts are considered has several practical implications such as how and whether individuals should be taught and assessed as distinct from the framework in which they will engage in care, the level of competence reasonably expected by individuals and teams, and the separation of joint collective actions between clinical case workload mixes.

As previously noted, it is not our intention in this chapter to decree either way the approach you must take to research and education within your own context. Rather, we hope that the debate we have presented causes you to pause and think about the relevance of these positions to practice in the field. We often assume individualist or holist positions in research or education without an awareness of the assumptions we are making and what this may mean for both our practice, and those who are affected by it—namely, educators, students, and patients. We hope you will use this chapter to reflect on your own assumptions regarding the relationships between individuals and collectives, how this influences your practice or the frameworks of education in which you are invested, and how you can make clear these assumptions and their possible impacts in your research and teaching from hereon in.

Table 14.2 Practice points

1	For programme directors, to consider individualism and holism approaches and their related inferences to current HPE designs, education, and assessment
2	For workplace educators, to consider what impacts their environment may have on the learning that can be achieved, to modify standards according to expectations
3	For educators and researchers, to reveal the relationships between interprofessional and interpersonal teams as both an individual and social phenomenon that can account for the multitude of pressures faced
4	For students, to work dynamically with social level factors to raise awareness of how they can mitigate their sense of self and self-regulated learning processes
5	For all, to critically analyse agency criterion and its ramifications for student learning through jointly teaching and assessing teams and individuals (and their actions) at appropriate points in education and service provision

The main insights of this chapter for research and practice within HPE are summarised in Table 14.2. For the ease of the reader of this chapter, we have divided these practice points into recommendations for various stakeholders in HPE research and education.

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Chapter 15
Ethics Education in the Health Professions

Bryan C. Pilkington

15.1 Introduction

Health Professions education can benefit from the embodiment of a diversity of perspectives. This is because critical engagement with one's own orientation toward health practices better situates one to understanding the perspectives of others—especially patients and clients—that one serves, as well as placing a practitioner in a better situation to reflect on, revise, and improve their own practice. Ethics education in the health professions is no different; however, it can raise additional complexities on two fronts. First, because the philosophical theories that often underlie ethical principles germane to the health professions are complicated, there may be a temptation to avoid their engagement in educating health professionals and restrict ethics content to professional norms and codes or to engage theories at a superficial level. Second, because health professions students often find themselves less versed in philosophy than other areas, their interests are seen to align with (and they are understood to benefit from) the aforementioned superficial theoretical engagement.

This chapter attempts to respond to these two complexities by highlighting key but intuitive ideas within three philosophical ethical approaches that undergird or influence health professions practices—deontological, consequentialist, and virtue-focused theories. This chapter does not offer a deep dive into any of these theories; rather it frames each within a basic discussion of the structure of human action. First, a deontological, rule-focused approach is discussed and connections to a

B. C. Pilkington (✉)
School of Health and Medical Sciences, Seton Hall University, Nutley, NJ, USA
e-mail: bryan.pilkington@shu.edu

College of Nursing, Seton Hall University, Nutley, NJ, USA

Department of Philosophy, Seton Hall University, Nutley, NJ, USA

Department of Medical Sciences, Hackensack Meridian School of Medicine, Nutley, NJ, USA

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common principle within healthcare—autonomy—is illustrated. Second, a consequentialist (or outcome-based) approach is discussed and connections to a common (and increasingly weighty) health field, public health ethics, is illustrated. Finally, a virtue-focused approach is discussed and connections to a health professions education is illustrated. The discussion of theoretical connections—first to a principle, second to a broad field, and finally to a self-reflective educational feature—allow for a scaffolding of educational complexity; this complexity is mirrored in the way in which each theory is discussed. The hope of the chapter is that educators will embrace this complexity, instead of shying away from it, and that health professions students will be all the better for it.

15.2 The Structure of Human Action

The complexity of philosophical theories and the interconnectedness of features of large philosophical systems can offer a daunting task for health professions students and a heavy lift for health professions educators in teaching ethics courses. Each can, unfortunately, reinforce the other, resulting in a perception that a superficial engagement with ethics ideas, or the jettisoning of ethics sources in favor of unmoored professional norms, are viable options for ethics education in the health professions. However, even those of us who recognize the complicated nature of much philosophical argumentation and believe that careful philosophical arguments repay rereading and the time devoted to them should admit that complexity builds as ethics deepens, and that an introductory course in ethics for the health professions need not (and should not) be a graduate seminar for dissertation-level philosophy students.

A case in point is the philosophical subfield of action theory. Though deep, wide, and with a great deal of nuanced implications for ethical theory and practice, one can take a simple insight from a focus on human action and frame a reasonably deep and understandable ethics education session or course. Consider the insight that every human action is made up of a person who performs it, the thing that is done, and what results from what is done.[1] Though there are a host of potential ways to complicate this picture, remaining at this level of complexity can help us organize three influential ethical theories and apply them to health professions ethics. This structure also offers a reasonably straightforward framework for students to understand and to classify or categorise other theories and approaches that they might take up, vis-à-vis "the big three." Consider the following threefold organizing suggestion:

1. Health professions students (and practitioners) most interested in the person, or the agent, performing the action might be drawn toward the virtues of practitioners of their chosen health profession;
2. Health professions students (and practitioners) most interested in the action that is performed by such practitioners might be drawn toward the rules or duties governing their chosen health profession;

[1] I am indebted to David Solomon for making this point clear to me.

3. Health professions students (and practitioners) most interested in the outcomes or achieving the best results regardless of who specifically they affect and how they are brought about, might be drawn toward ways to optimize the effects of their chosen health profession's practices.

In this way, an insight can be drawn from what is a complex philosophical field of study and employed to aid health professions students in orienting themselves toward an ethics approach and offer deeper resources than they may otherwise have engaged. The following sections take up a theory connected to each point about the structure of human action, as mentioned above, beginning with rules, moving to outcomes, and concluding with virtues.

15.3 Rules in Ethics

Encounters between healthcare professionals and patients or clients can be some of the weightiest interactions in a person's life. Persons hold their health very dear, albeit among other things, and they often seek the care of health professionals when their health is compromised or put in jeopardy. Approaching another person from a state of vulnerability—both in terms of a weakened state, but also the commonly vast difference in knowledge[2] regarding illness—is not easy and thus places a burden on health professionals to take particular care in responding. One common guide for proper response is to follow the rules that govern one's profession or the ethical rules that might govern this particular kind of interaction. One feature of ethical care that health professionals, who are interested in ethical rules, must reflect on, is the autonomy-paternalism spectrum.[3] Educators might find that this spectrum is also helpful in conceptualizing ethics sessions for students. What this approach suggests is that ethical rules for health interactions (as well as educational ones) are created in response to the specialness of particular persons, those who are sick (or who seek learning) and who can give rules to themselves and follow those rules (hence the connection to autonomy). Three points frame the remainder of this section; first, context: history matters; second, knowledge: understanding the perspectives of others is necessary but not always easy; third, patients (or students) as persons: to avoid ethical pitfalls, seek to see the patient (or student) as a person.

[2] Put to the side first-hand knowledge of an experiential sort.

[3] This image is a rough approximation; a better, but less clear image is that of actions, behaviours, or approaches to the health profession-patient encounter as gravitating toward different poles, an autonomy-affirming pole, and a paternalism-embodying pole.

15.3.1 History Matters

Healthcare professionals are in the challenging position of aiding others without possessing complete information or full control; educators can find themselves in similar positions. Though the former (information) can be remedied to varying extents depending on the situation, the latter should not be. Health professionals are not merely technicians, though technical abilities are important,[4] they are also people who practice *with* patients, as members of a broader profession, within multiple traditions of practice, and often focusing on one of a variety of specialties. Were health professionals technicians, then taking care to respect the autonomy of their patients and guarding against overly paternalistic approaches to their practice *with* a patient would be of less concern. Patients, as persons, possess values, goals, and interests that might be very different from the physician with whom they share in the therapeutic endeavour; this can also be said of teachers and students, though there may be a unifying cause in their shared engagement in a particular profession. Each patient has their own life history, relationships, understandings of the world and their place in it, and reasons that they have sought out the care of a health professional. Because the patient is a person and not merely a problem to solve, even if perfect technique is displayed, the health professional has not satisfied their ethical obligations (and it is worth noting here that rule-based ethics are often deontological in nature, that is, they focus on duties). It is important to highlight that though healthcare practices bring great goods to many, ethical violations within their history strengthen the need to treat patients as persons and to follow rules that arise from engagement with something so special[5]; as does the overall change in context, helpfully summarized by Kilbride and Joffe (2018) in a recent piece in the *Journal of the American Medical Association* (JAMA) about members of one health profession, physicians:

> The rejection of medical paternalism in favor of respect for patient autonomy transformed the patient-physician relationship. Historically, medicine and society subscribed to the ethical norm that the physician's main duty was to promote the patient's welfare, even at the expense of the latter's autonomy. A central assumption of the paternalistic framework was that physicians, because of their medical expertise, knew best what was in the best interest of patients (1973).

[4] See ethicist William May's classic medical ethics text, *The Physician's Covenant: Images of the Healer in Medical Ethics* (Westminster John Knox Press, 2000) for a discussion of technicians and other images of physicians—which can be applied more broadly to all health professions—that guide ethical approaches to healthcare.

[5] Some historical examples include violations of freedom in favor of "best interests" (for a discussion of the famous Dax Cowart case, see Engelhardt, H. T. 1989. Freedom vs. best interest: A conflict at the roots of health care. In Dax's Case: Essays in Medical Ethics and Human Meaning, ed. L. Kliever, 79–96. Dallas, TX: Southern Methodist University Press.), racism in medical research and practice (including, failures to attend to internalized racism (see Smith, P. 2019. Moral Status and the Care of Impaired Newborns: An African American Protestant Perspective), racism in research and race-based medicine (Brandt, A. 1978. Racism and Research: The Case of the Tuskegee Syphilis Study, *The Hastings Center Report*, Vol. 8, No. 6 and Johnson, K. 2019. *Medical Stigmata: Race, Medicine, and the Pursuit of Theological Liberation*).

Before turning to the challenge of perspective taking and the need for autonomy-affirming strategies, it is worth highlighting lessons that can be drawn for education. Attending to students as people opens up an educational space wherein teacher and student are partners—"joint adventurers", to borrow a phrase from the ethicist Ramsey (1970) who coined the term "patient as person"—suggesting flexibility in small things, like examples to be used, and large things, like delivery methods. This kind of approach would not be aligned well with a banking model of education—dropping facts to be memorized into a student's head (for a detailed exploration of resistance against the banking model of education, see Chapter 4)—but rather, as with health-focused work, it is important to place students (or patients) in the best possible position for them to succeed (learning material and applying it, or living a healthy life). Bringing these two areas together, even suggests—in a concrete way—specific questions around which to theme sessions. For example, attending to context and history, might suggest an assignment like this:

> *Familiarize yourself with a few situations throughout the history of your future health profession in which you believe ethical rules were violated or where a patient or client was not treated as a person; describe two such situations.*

15.3.2 Knowledge and Perspective Taking

The historical change in orientation *from* healthcare professionals, as those with knowledge of what is in a patient's or client's best interest and informing them what the course of treatment would be *to* a relationship of shared decision-making that has been described by terms like therapeutic alliance or "joint-adventurers", is due, in part, to an emphasis on the concept of autonomy. Autonomy is one of the "four principles" of bioethics (Beauchamp and Childress 2019)[6] and, some argue, the most important of the four (Post and Blustein 2015). The concept's role in ethics has its roots in philosophy, is connected with a rules-focused approach, and is especially at home within the Kantian Tradition.[7] A focus on the concept highlights that persons are self-governing or, according to the Greek roots of the term, that they give the law unto themselves. Such persons are described in the Belmont Report, an early document codifying healthcare practice and research norms, as those "…capable of deliberation about personal goals and of acting under the direction of such deliberation" (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979, 4).[8] It should be clear that a health professional-patient relationship defined solely by the health professional would not respect the patient as a person because they would not have an opportunity for self-rule. Rather, a hallmark of autonomy-affirming practices would be the offering of reasons to a person to

[6] Though principlism is only one approach to ethical medical practice, it is a dominant approach.

[7] See, for example, Kant's 1785 work, Groundwork for the Metaphysics of Morals.

[8] It is worth noting that "early" here refers to modern medical ethics and "bioethics" but not to the thinking about these issues broadly.

evaluate for themselves and then the opportunity to act on those reasons; this respect is exemplified through the informed consent process.[9] In fact, the Belmont Report translates the principle of autonomy (which it refers to as "respect for persons") to the application of informed consent. The converse of this approach is often described as paternalism, which is frowned up in healthcare because paternalistic practices fail to treat patients as persons. This is not to say that good health professionals do not exemplify some virtues also possessed by good ***parents***, the image at its linguistic roots of paternalism, such as care, compassion, and even great effort to safeguard. Rather, as William May (2000) suggests, "the healer overreaches when he or she justifies overriding the patient's wants, wishes, decisions, and judgment on the grounds that the adult patient is a child, incapable of knowing his or her own good" (39). Similarly, this can occur in education when views or approaches are forced on students or taught as the only option, instead of allowing students to adopt an approach based on the best available data and arguments, given their own situation.

Paternalistic relationships suggest that the "parent" figure knows best, and models for health professional-patient relationships often fail, ethically,[10] as noted above, because even if they are technical experts in their craft, health professionals are not rulers over their patients' goals and aims. As highlighted in Cavanaugh's (2018) recent medical ethics text on the Hippocratic Oath, "A technique, in itself, does not include determination toward an end and away from what opposes that end while an ethic necessarily does" (141). Shared decision-making models are most fruitful because they bring together the expertise of both the health professional and the patient and can be guided by ethically sound rules. Health professions students attracted to a rules-based approach should keep in mind that the patient is the ultimate decision-maker, thus rooting their approach in the recognition that patients are (or are capable of) self-governing. This approach is also epistemologically stronger (for discussion of the term 'epistemology', see Chap. 10) because even if a patient were to share a good deal of information about her life history, health professionals would still not possess sufficient information to act paternalistically. Even if such decision-making were ethically acceptable, health professionals cannot fully embody the perspective of their patients. A good (ethically rule-following) health professional will learn enough about a patient to be empathetic, but not enough to decide for them.

15.3.3 Patient as Person

Simply put, an ethical approach to medical encounters requires that practitioners see their patients as persons. Failure to do so, not only by practitioners but by the healthcare and societal institutions of which they are (and have historically been)

[9] This is especially the case when informed consent is not thought of as a document to be signed but as part of a process of shared decision-making.

[10] Put to the side practical considerations about the failure rates or compliance problems if shared goals are not found.

a part, has led to unethical treatment of patients. One feature of treating patients as persons is to respect them as autonomous agents. In so doing, physicians should work toward relationships with patients that are defined by shared decision making and not by paternalism. Ethical physicians are neither purely technicians, nor do they fall into the trap of playing God; a healthy respect for autonomy aids in maintaining that balance.

15.4 Outcomes in Ethics

Though all health professionals are interested in good outcomes, students most interested in good outcomes—and less interested in who does what to achieve those outcomes—might be drawn toward a consequentialist approach to ethical practice. In this section, an outcome-based ethic is described and the prominent role it can play in public health ethics is discussed.

Consequentialism is the idea that only (or primarily) the results, effects, or *consequences* of an action (broadly understood) determine its rightness. According to this kind of philosophical perspective, if a health professional wants to know whether an action is right or not, they should examine the results from performing or not performing some action. Consequentialism is not a full theory, in the sense that it cannot guide a health professional's actions without first adopting a rubric to evaluate those outcomes; that is, we need a way to determine and measure what good results are. Arguably, the most influential consequentialist theory has been put forth by John Stuart Mill, who advocated for utilitarianism. Utilitarians evaluate the consequences of an action in terms of its utility (a combination of pleasure and the absence of pain) and, though Mill's utilitarianism and other versions of it get complicated quickly in terms of how to evaluate and measure outcomes, the key to this ethical theory is the maximization of those good results.[11]

Teaching utilitarianism to health professions students can be aided with the use of a decision matrix. Figure 15.1 is a very basic one:

Consider one health professional, say a surgeon, who must decide between performing a standard surgical intervention (A), attempting a new but not experimental surgery (B), or not determining that the patient is not a candidate for surgery and referring them to internal medicine (C). Suppose this action affects three people—the patient (1), her mother (2), and her daughter (3). The numbers in this chart signify pleasure (positive integer) or pain (negative integer). Utilitarians are looking to maximize overall utility and so the correct answer is C. Though overly simplistic, this chart is instructive. It illustrates the main aim of this approach: to maximize the overall utility; not the utility of a particular person or a set of people, but of everyone. This is

[11] Mill's guiding principle is known as the Greatest Happiness Principle, which states that "…actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness; by happiness is intended pleasure and the absence of pain; by unhappiness, pain, and the privation of pleasure." (Mill, J. S. 1863. *Utilitarianism.* London, Parker, son, and Bourn, 1863).

		Actions		
		A	B	C
Persons	1	7	12	4
	2	7	-6	23
	3	7	12	-3
Total		21	18	24

Fig. 15.1 Decision Matrix

similar to current trends in public health ethics. For example, consider the recent and ongoing COVID-19 pandemic. Much thinking has focused on all (or at least large groups of people) and not on individuals. An occupational therapist may determine that she will see her clients virtually, even though her diagnostic training and practice were based on in person encounters. If she does this because she is concerned about the spread of the virus, she may be appealing to a consequentialist approach. This raises important questions about telehealth, facile execution of standards of care, and even the weighty philosophical question of "Who counts as one's patient?" No person, on a utilitarian view, receives any heavier weighting in the calculating of results than another—so health professions students may find this approach's egalitarian or democratic nature attractive, especially during their early training. However, as they advance in their training and begin their practice, they may be inclined toward other approaches if they develop relationships with clients or believe they owe something to a particular patient "of theirs" as opposed to another. This language suggests a duty-orientation that might return them to a deontological, rule-based approach.

Some negative features of Utilitarianism, which can be gleaned from the matrix, exist, as well. It is an instructive exercise for health professions students to discern these themes on their own and report back to a larger group for discussion and for the sharing of self-reflection. For example, students interested in social justice and health might opt for answer A and find the lack of equity or equality[12] in choice

[12] Without further context and information added to the decision matrix, this distinction cannot be made. However, building on this basic matrix to fit the needs of a particular group of health

C to be objectionable. Choosing C also means that the decider is comfortable with some persons (Person 3 in this case) being harmed. This is not to say that Utilitarians support harm, but that—as occurs in many public health determinations—they accept that some persons will be negatively affected (be it by direct harm, resources going elsewhere, or other things, such as their liberties, being curtailed) in order that the total utility is maximized.

In addition to this kind of exercise being useful in ethics education sessions, it may also be instructive in framing classroom pedagogy. Given different learning styles, speeds, abilities, and the way that differently abled persons interact with the structures of the world, reflecting on the distinction between individual students and a class of students is useful. Instructors may ask, in reflecting on the success of a session, whether the class did well or whether all their individual students did well? Do they allow for assignment flexibility, or do they require the same assignment as a way to consistently measure performance? Have they succeeded if the class average is greater than in previous years or if the most students pass the relevant professional exam or do base the course's success on the success of each individual student?

Finally, it is worth noting that there are some conceptual challenges that health professions students—and those relying on the ideas of this section to build a session or theme of a course—should be aware of. First, determining how to measure utility, or whatever the good to be maximized is, can be challenging. Is Person 3 in Action C really at a negative 3? Or could it be a negative 1 or a negative 5? This precision matters in an approach that takes into account an aggregate number to determine the rightness of an action. And it is the rightness of the action that Utilitarians claim; a good Utilitarian does not suggest C, she claims that C is the ethically required action. In the complicated world of healthcare, the importance of nuanced evaluation is clear and very much needed for this ethical approach to be adopted. Second, where do you draw the line? Utilitarians must constantly add in new information to their calculations given that all implications from a decision are relevant to their calculus—recall, it is the consequences that they focus on, including the consequences of those consequences, and so on. Determining what is a relevant consequence is, thus, an important question. Might health professionals evaluate their work in terms of the success of a treatment plan, the overall health of their patient, or the health of members of their community? Even the second option is complicated: Should health professionals work to address climate change or to bring clean water to dry areas or healthy nutrition to food deserts? What if these factors affect their patients' health? A deeper and richer discussion is needed to address these questions, but in the very least health professionals and those teaching them must arrive at answers about what counts as health, healthcare, and what they aim to maximize if they adopt this view.

Analogous questions arise in the teaching of health professions. What properly falls into the purview of an instructor if she adopts a consequentialist approach as her classroom ethic? Is she on the hook for the maximally happy lives of her students, class, program? Should she draw the line at the passing of the professional licensure

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professions students is an excellent way to broaden the ethics conversation and to elicit particular self-reflections about students' values.

test or, more modestly, should she aim to teach a particular set of skills and attitudes which she finds to be the most successful for a practitioner of her craft? In the final section of this chapter, we turn to this last suggestion, which is connected to a discussion of virtue.

15.5 A Virtue-Focused Ethic

The third, and final, approach to be discussed in this chapter is virtue ethics. For those health professions students interested most in the person performing the action in our original tripartite structure or for teachers who focus on students—not a whole class, school, or particular exam metrics—and find the inculcation and support of character traits or dispositions that lead to good health practice to be attractive, a virtue-focused ethic might the right fit. That said, teaching virtues can be more complicated than teaching the other two ethical approaches and it can be trickier to regulate and measure in practice. As with the other two theories, health professions students and teachers are encouraged to adopt the approach that best fits their own aims, profession, and personality.

Philosophical discussion of virtue often focuses on the work of Aristotle. A paradoxical combination of intuitive appeal and complication can be gleaned simply from the question that frames Aristotle's approach. As opposed to asking how to maximize utility or how to arrive at the right rules to govern ethical action, he is motivated by a more practical question: How do we live a good human life? More recently, Alasdair MacIntyre (2007) has argued for the importance of virtues and health professionals, such as Edmund Pellegrino (1985) have held a similar focus in building an ethic specific to a health profession.

One challenge in discussing a virtue approach to health professional teaching and practice is that particular virtues might be tied, very broadly, to human beings or very particularly to individual professions. Thus, there is a risk of being both too broad and not specific enough in executing the aims of this section. To fix ideas, the remainder of this section draws the reader's attention to five key features of virtue-focused approaches; the hope of this section is that the reader will indulge any murkiness in conceptual articulation and apply the ideas—as they fit—in their own teaching and practice.

15.5.1 The Five Keys to Virtue Education in the Health Professions

First, experiences matter. Aristotle ([350 BCE] 1999) is quoted as saying in Nicomachean Ethics Book 1, "…a *young* person is not a proper hearer of lectures on political science; for he is inexperienced in the actions that occur in life, but its

discussions start from these and are about these…" (1095). The key to understanding this claim is that it is not about youth, but about the knowledge that comes from lived experience. The seasoned clinician is often able to "see" things that trainees do not.

Second, Aristotle thought that in order to respond well to situations, persons need to be brought up with good habits. Consider any kind of complex activity—diagnosing speech pathology, hitting a baseball, dancing a ballet, overseeing a hospital system—and who might be best situated to make important determinations and perform the needed actions relative to that activity. Someone with experience who has been brought up in the right sorts of ways so that she responds well to unforeseen issues, understands what technical competence in the relevant crafts entails, and whose feedback mechanisms are properly aligned with the endeavor's goals is the right choice. Such a person will choose well, given her knowledge, expertise, and the lack of conflicts of interest (or, as Aristotle would put it, she feels pleasure at the right sorts of things). More simply put: if you practice good habits, you're more likely to get things right.

The next key idea is somewhat controversial. Aristotle argued that different beings have different functions and that in order to be happy, one needs to perform one's function well. This applies to everything: good doorstops hold doors in place, good sailors sail well, good Physician Assistants (or Associates) care for patients well. This notion is controversial when applied to human beings as a whole, but offers a useful lesson, even if intuitive, for practitioners of all sorts. Health professionals who perform their functions well, will gain more joy from their craft. Teachers who construct a course of study and engage students well, will enjoy teaching more.[13]

A related (fourth) key idea involves a description of how one becomes good and about feeling good, which connects to the aforementioned role that habits play in forming our characters and to the subsequent topic of practical wisdom. For Aristotle, persons become good by performing actions in accord with correct reason; that is, a virtuous person must: (1) know that what is she is doing is a virtuous action; (2) decide to do that action; (3) do that action from a firm and unchanging state. In other words, the person of practical wisdom or—for our purposes—an excellent healthcare practitioner—is one who chooses the right option, knowing it is correct, and does so in light of their well-formed character. This is a lesson well known by many teachers: the right answer does not define a successful student; how a student gets to the right answer matters.

The fifth, and final, key point focuses on a moral exemplar: the person of practical wisdom (for a detailed discussion of practical wisdom in health professions education, see Chap. 20). In fact, Aristotle ([350 BCE] 1999) is said to have defined virtue

[13] This idea, that those who perform their function well will be happy, has more depth than this in text description suggests. What Aristotle means by happiness is different from a Utilitarian, like Mill; for Aristotle, happiness is eudaimonia, a Greek word meaning something like "good- or well-spirited," that is, to have a good demon. In his investigation and exploration of eudaimonia, he argues that whatever it is, it will be complete, self-sufficient, and not capable of improvement; and after surveying four different kinds of lives: those devoted to pleasure (hedonism), those devoted to being honored (politics), those devoted to money, and—the winner—those devoted to living a deeply reflective life.

in Nicomachean Ethics Book 2 as "…a state of character concerned with choice, lying in a *mean*, that is, the mean relative to us, this being determined by a rational principle, and by that principle by which the man of practical wisdom would determine it…" (1106). There is much to be unpacked in this description, but for our purposes the image of the person of practical wisdom for a virtue-focused ethics of the health professions and for those who teach in the health professions will do a good deal of philosophical heavy-lifting. If a health professional aims to do the right thing, according to this approach, they ought to do what the person of practical wisdom would do. A good nurse will care as the best nurse does, not overstepping their bounds while remaining fully attentive to their patient and their patient's family. They will empathise with their patient, ensure that their patient is fully supported, informed, and advocated for, and that their therapy (and all this entails) proceeds as it should. Thus, a good nurse possesses a host of virtues, including patience, empathy, and care.

Though an analogous description could be offered of a teacher of the health professions, there is a closer connection between the two areas—health practice and the training of health practitioners—through the notion of mentorship. The key insight for health professions instructors and students vis-à-vis the education that they support and take part in, is the importance of mentorship. Mentors—at their best—are Aristotle's practically wise persons, or the aforementioned "excellent healthcare professionals". In mentors, ethical practice and teaching come together. If one desires to be a great nurse, one ought to do what great nurses do and to find out what that is—in all of its nuanced detail—one must follow that excellent practitioner closely. It is not enough, on this ethical approach, to follow rules to guide ethical practice or to work for the best results, one can only have acted ethically when one practically reasons well. Thus, the future nurse should see how her mentor practically reasons through medically (and morally) complicated healthcare situations. Aristotle thought that virtues—dispositions toward the good—of these persons reside in a mean and that vices live on either side of this mean. The practically wise nurse bravely enters into the challenging conversation in which they are to disclose a medical error. They do not cowardly hide behind their hospital's legal team or try to cover up the mistake; nor do they brazenly storm into the family's home to declare with rashness what has happened. The physician who believes a risky surgical intervention is the best option for a patient, medically speaking, does not bully their patient into the procedure, nor do they fail to share their surgical expertise; but to understand how to do this well involves not only following the rules of informed consent, but the best methods and practices of an empathic, skilled expert involved in a shared decision-making process with a patient.

This approach, like the other two theories, has its own drawbacks. It has been described as perfectionist in always aiming toward excellence and not realistic enough in the necessary accompanying assessments of health professionals and health professions students—many are excellent, but many more are good, and

many are serviceable. Might aiming for excellence miss that good practice is sufficient? Secondly, obtaining the right habits and inculcating virtues is not easy nor is it easy to measure, raising questions for training and evaluation in the health professions. A final concern about this approach is that relying on the person of practical wisdom—or the excellent healthcare practitioner—is not as easy or as straightforward as following a set of rules. It lacks, to borrow from the philosophical literature, the action-guidingness that we seek in ethical theories. Those health professions students and teachers attracted to this approach may, nonetheless, seek out mentors and to serve as mentors because they understand the messy, murky, and nuanced arenas that healthcare takes place in and the complicated beings that humans are.

15.6 Conclusion

This chapter has offered descriptions of three ethical theories that could inform health professionals' practice and the education of health professions students. In doing so, it attempted to satisfy its aim of responding to the complexity of some philosophical material and the lack of familiarity of some health professions students with philosophical approaches by offering clear and intuitive descriptions and avoiding some of the (albeit important) more complex and less practically relevant features of these theories. It highlighted connections between theories and common principles, such as the connection between a rule-based ethic and autonomy, between theories and large fields like public health ethics, and between theories and teaching through the discussion of virtue ethics and mentorship. Health professionals and teachers of the health professions students need not shy away from the theories that should and do inform their professional codes of ethics nor complex philosophical ideas. With the structure of human action as a guide and by reflecting on the three ethical theories connected to different components of it, ethics education in the health professions can be robust, meet the needs of teachers and students, and be an interesting and impactful part of a student's training (Table 15.1).

Table 15.1 Practice points

1	Employ ethical theories, not simply professional norms, in health professions instruction
2	Build mentorship opportunities into health professions, teaching, learning, and practice
3	Offer diverse ethical approaches to health professions students, allowing them to choose the best fit
4	Embrace philosophical complexity in the ethics education of health professions students
5	Connect ethical theories to daily practices, teaching, and related fields of import to highlight their benefit

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Chapter 16
Climate Change and Health Care Education

Cristina Richie

16.1 Introduction: An Overview of Medical Ethics Education

Education is the cornerstone of becoming a competent health care professional. Ethics education in medical schools and the allied health sciences support the development of clinical integrity and reinforces the foundational commitment of medicine to "do no harm." Ethical theory underpinning medical ethics in modern Western societies relies heavily on the four principles of biomedical ethics, developed by Tom Beauchamp and James Childress in 1979. Also known as the "Georgetown Mantra," the principles of respect for patient autonomy, beneficence (do good), non-maleficence (do not harm), and justice dominated medical education. While the four principles of biomedical ethics are at the core of medical ethics education, the importance of the natural world and interconnectedness of humans with larger ecosystems is also taught in health professions education.

In this chapter, I first provide a brief history of the development of health care ethics with a focus on the modern theory and content in medical schools. I then examine the current placement of climate change ethics in medical school education, using the UK and US as examples for broader health care education. Finally, I identify five practice points for broader integration of climate change ethics in health care education, highlighting opportunities—which include broad learning objectives and flexible delivery methods—and challenges, such as room in the curriculum, instructor confidence and perceived irrelevance.

In the conclusion, I make a call to include climate change ethics in all medical and allied health science education.

C. Richie (✉)
Philosophy and Ethics of Technology, Technische Universiteit Delft, Delft, The Netherlands
e-mail: c.s.richie@tudelft.nl

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16.1.1 History of Medical Ethics

Codes of professionalism and ethics were initially within the domains of physicians guilds and integrated with medical training. From the beginning of medicine, "ethics" education has been part and parcel of socialization into the profession. Take, for example, the statements of Asclepius on the ethics of futile care. Plato (1985) records that Asclepius "did not think it worthwhile to treat a man incapable of living a normal life since such a one is of no use to himself or to the state" (407). That is, extending life merely for the sake of existence is not the purpose of medicine; rather, a physician's moral compass ought to be directed at benefit to the State. In the modern era, rule-based ethical systems like deontology—which makes requirements on moral agents irrespective of the consequences (Korsgaard 2014)—became the standard form of ethics education in medical schools (Zhuravleva et al. 1999). Medical deontology focused on the duties and ethical actions of doctors in providing medical care. Medical ethics also developed outside of medical schools.

Religious scholars were among the first "medical ethicists" (Curran 2003, 114). In Catholicism, for instance, a rich system for adjudicating the morality of medical dilemmas was produced, tracing back to moral manuals like Heribert Jone's (1946) *Moral Theology*. Of course, many of the principles employed in health care ethics were developed long before Jone, starting with Thomas Aquinas (2008). These historical moral principles were then developed using casuistry, a case study method for contemporary medical dilemmas.[1] Significant theologically-based intellectual developments in medical ethics in the United States came from Gerald Kelly (1956) who developed the principle of totality and the distinction between ordinary and extraordinary means (Jackson 2015). The principle of totality states that a body or physical system ought to remain intact and not be separated (Kelly 1956). This became foundational for discussions on organ donation, amputation, and artificial fertilization. The distinction between ordinary and extraordinary means became relevant to end of life care, whereby ordinary means might be natural feeding and extraordinary means might be artificial life support) (Kelly 1950).

James Gustafson (1975) also applied ethical theory to health care ethics, such as the principle of the double effect, which states that if an action has two effects and one is morally right and one is morally wrong, then the action can be acceptable if the intention is for the morally right effect (Cahill 2012). This was relevant in palliative care which can lead to terminal sedation. The principle of cooperation, which examined an agent's proximity to participation in morally wrong actions helped nurses care for women who had abortions, but not perform the abortion directly. The principle of proportionalism stated that morally wrong actions must have proportional, compelling reasons to justify them and this nuanced the principles of totality

[1] For an excellent overview of some of these specific uses see: Keenan, James and Shannon, Thomas eds. 1995. *The Context of Casuistry.* Washington: Georgetown University.; Keenan, James. 2001. Notes on Moral Theology: Moral Theology and History. *Theological Studies* 62: 86–104. For a modern application, see Keenan, James. 1999. Applying the Seventeenth-Century Casuistry of Accommodation to HIV Prevention. *Theological Studies* 60: 492–512.

and cooperation. Gustafson's theological reflection influenced both his Catholic and Protestant students who later became prominent and diverse medical ethicists, like Lisa Sowle Cahill, Albert Jonsen, and Stanley Hauerwas. Cahill (2004, 2005) made major contributions to globally-focused health care, Albert Jonsen's work on end of life and beginning of life issues is seminal (Jonsen and Garland 1976; Jonsen et al. 1982), and Stanley Hauerwas' (1982, 1994) contribution to disability studies remains a classic work. The influence of Catholic theology—in particular—on medical ethics was prominent in other mid-twentieth century scholars like William May (1977), Richard McCormick (1980) and Charles Curran (1979).

The development of health care ethics from outside the medical school also evolved from non-theological perspectives (Beauchamp and Childress 1979), although many of the ethicists did have personal spiritual commitments. Daniel Callahan (1990) cites Joseph Fletcher's 1954 book *Morals and Medicine* as "the first truly fresh manifestation of a growing interest in medical ethics in the post-World War II era" (3). He notes that, later, non-religious health care ethics emerged "during the 1960s and 1970s in an era of affluence and social utopianism…(and) for medicine, it was a time that combined magnificent theoretical and clinical achievements with uncommonly difficult moral problems" (ibid., 2). In support of these academic developments, Centers dedicated to bioethical inquiry, which were comprised of theologians, philosophers, lawyers, policymakers, and doctors—like the Hastings Center[2]—emerged. Other significant developments in Western medical ethics include Paul Ramsey's 1970 book, *The Patient as Person*, a 1974 conference on bioethics at Haverford College (Callahan 1990), and the 1978 Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research 1979). Today, particularly in Western liberal societies where the pursuit of health and longevity is often in tension with other social values like sustainability, expense, and access, balancing moral boundaries with boundless scientific developments requires discernment filtered through ethical theory.

16.1.2 Modern Day Medical Ethics—Theory

In 1927, Fritz Jahr described bio-ethics as "the assumption of moral obligations not only towards humans, but towards all forms of life" (Jahr and Sass 2010, 227). Almost half a century later, the term "bioethics" appeared in English, with a remarkably similar meaning. In 1971, oncologist Van Rensselaer Potter used the term "bioethics" to describe "a global perspective with an ecological focus on how we as humans will guide our adaptations to our environment" (Potter 1988, 10). Both Jahr and Potter recognized the interconnectedness of humans and the natural environment, thus connecting bioethics to the natural world, the world outside of healthcare. Indeed, the 1978 *Encyclopedia of Bioethics* defines bioethics as the ethical system that addresses "problems of interference with other living beings… and generally

[2] For further information on the Hastings Center, see: https://www.thehastingscenter.org/.

everything related to the balance of the ecosystem" (Reich 1978, 19), thus, indicating that the environment was an integral part of the original concept of bioethics (Richie 2014).

Yet, a second way of defining bioethics has appeared within academia and medicine. The so-called Georgetown mantra—respect for patient autonomy, beneficence, non-maleficence, and justice—which was developed by Tom Beauchamp from the Philosophy Department and James Childress of the Religious Studies department at Georgetown University (1979)—became the standard ethical system for medical schools. Following this formalization of biomedical ethics, numerous research centers connected to universities and hospitals arose, focused on the four principles of bioethics to the exclusion of Jahr and Potter's original conceptualisation of bioethics (Sgreccia and Tambone 2003). Thus, the environmental component of biomedical ethics was forgotten by students, teachers, and practitioners.

The evolution of the concept of bioethics—which was formerly attentive to nature and interconnected systems—into a more technological-individual field, gave the appearance that environmental bioethics was a separate discipline from academic bioethics (Reich 1995). This widespread misperception—resulting in the exclusion of bio-networks from bioethics—has influenced the theory and praxis of nearly every ecologist, bioethicist, and health care educator thereafter. Indeed, when Potter published his second and final book *Global Bioethics: Building on the Leopold Legacy* in 1998, he lamented that modern bioethics went in a drastically different direction than he envisioned, writing:

> With the focus on medical options, the fact that bioethics had been proposed to combine human values with ecological facts was forgotten by many: the ethics of how far to exercise technological options in the exploitation of the environment was not associated with the term bioethics (1–2).

16.1.3 Modern Day Medical Ethics—Instruction

Ostensibly, the philosophical contributions of Beauchamp and Childress legitimized the modern practice of non-clinicians teaching medical ethics. However, bioethicists have been muckraked, called "thieves of virtue" (Koch 2014), who intervene in medicine when they should not, since they are not medical professionals, but rather trained in theology or philosophy (Moreno 2006). Whilst many medical and health professional schools utilize an ethics or bioethics department for the education of students, some smaller schools have only one bioethicist who teaches courses in health care ethics.[3]

[3] In Ireland see: Ryan-Fogarty, Yvonne, O'Regan, Bernadette and Moles, Richard. 2016. Greening healthcare: systematic implementation of environmental programmes in a university teaching hospital. *Journal of Cleaner Production* 126: 248–259. In Australia: see Maxwell, Janie and Blashki, Grant. 2016. Teaching about climate change in medical education: an opportunity. *Journal of Public Health Research* 5: 14–20.

Despite such variation, ethics is a feature of modern health care education (Reynolds and Tansey 2007). In the United States, medical schools follow the Association of American Medical Colleges (AAMC) standards for ethics education, with courses running across all four years of MD programmes. By 2000, a study of 91 reporting medical schools in the US and Canada showed that all of the medical schools offered some form of ethics education (Lehmann et al. 2004). Significantly, "Deans who reported having a faculty member whose primary responsibility was to teach medical ethics were twice as likely to have mandatory introductory ethics course (64% versus 32%)" (ibid. 684). The UK also has standards of medical ethics education. In 1993, the General Medical Council (GMC)'s *Tomorrow's Doctors* "place(d) a new obligation on medical schools to include ethics as part of the core curriculum for the training of medical students" (Fulford et al. 1997). All reporting schools indicated that they had ethics resources available to students, primarily in the form of content.

16.1.4 Modern Day Medical Ethics—Content

Content is frequently a point of contention in health professions education. Tension between curriculum time (Lehmann et al. 2004) and differing faculty views on the necessity—or frequency—of ethics lead to differences in how much curriculum time is deveoted to the ethical formation of healthcare professionals and which topics are covered. A cursory glance at the content areas for medical ethics education in the United States (Miles et al. 1989) and the UK (Consensus Statement by Teachers of Medical Ethics and Law in UK Medical Schools 1998) reveal a handful of topics—such as religious theory, duty to treat those with HIV, and threat of Nuclear war—have fallen into present day disfavour as they are viewed as irrelevant, while other current topics—such as genetics or reproduction—are presented in curricula. Developments in health care and ethics make content a moving target. The Coronavirus Pandemic of 2020 led to an influx of webinars on ethics,[4] pandemic responses,[5] triage and allocation,[6] and other topics[7] aimed at health care students and educators. Despite changes

[4] See, for example: Darwich, Bahaa. 2020. Webinar Series: Bioethics and Covid-19 Response in the Arab region. UNESCO. At https://en.unesco.org/news/webinar-series-bioethics-and-covid-19-response-arab-region.

[5] See, for example: UNESCO Chair in Bioethics Webinar Series Panel Discussions on Medical Ethics in the Wake of the COVID. 2020. Medical Ethics in the wake of the COVID 19 Pandemics: The Ethics of Mandatory and Voluntary Interventions: *Nonpharmaceutical Interventions -Isolation, Quarantine, Social distancing and Closures*. At https://register.gotowebinar.com/register/4680770938996247822.

[6] See, for example: NASEM Health and Medicine. 2020. Public Workshop: Equitable Allocation of Vaccine for the Novel Coronavirus. At https://www.eventbrite.com/e/public-workshop-equitable-allocation-of-vaccine-for-the-novel-coronavirus-tickets-115438574885.

[7] See, for example: Empire State Bioethics Consortium. 2020. COVID-19 and Ethics webinars, What are the obligations of the State during a Pandemic?. At https://www.youtube.com/watch?v=GJakMSYPKsE; Empire State Bioethics Consortium. 2020. Ethics Consultations During COVID-19. At https://www.youtube.com/watch?v=kQGqYGYgSyE; Empire State Bioethics Consortium.

in content and subject matter, modern health care ethics education retains a core commitment to broader social issues like justice (Jotkowitz et al. 2004), antiracism (Braun and Saunders 2017), and environmental sustainability.

To be sure, environmental sustainability does not have to be placed within *ethics* curriculum in medical schools, although it certainly has a strong rationale for being there. Whether addressed as an ethical issue, or as a matter of general educational competency, the two prongs of climate change related health hazards (as a matter of patient health) and the carbon emissions of healthcare (as a matter of professional ethics) define environmental topics that health professions education might cover.

16.2 Models of Climate Change Ethics in Medical Education

Although medical schools in at least 92 countries (El Omrani et al. 2020)[8] have topics related to climate change ethics and environmental sustainability in their curricula, the most in-depth data comes from the UK and US, thus each country's curriculum use will be discussed. This information has application for broader health professions education.

16.2.1 Climate Change Ethics in UK Medical Education

There is a small but significant amount of attention to climate ethics in medical school curriculum in the United Kingdom (Walpole et al. 2015; Walpole and Mortimer 2016; Maxwell and Blashki 2016). In 2015, a team of four professors from Hull York Medical School, the Centre for Sustainable Healthcare at Oxford, the Medical School at the University College London, and the Medical School at the University of Bristol spearheaded a consultation of "healthcare students, healthcare educators and other key stakeholders" to discuss environmental sustainability in medical education and define learning objectives for implementation of such curriculum (Walpole et al. 2015, 191). The outcomes of this project were reported by Walpole and Mortimer in 2016 and are indicative of successful integration of environmental topics into medical school curriculum in the UK, with relevance for broader health professional education.

The scholars leading the consultation offered four basic rationale for their project:

2020. The Importance of Palliative Care During The Covid-19 Pandemic. At https://www.youtube.com/watch?v=PXuNVYLHhHE&feature=youtu.be; Empire State Bioethics Consortium. 2020. Inequality, Vulnerability, and Health Justice: Learning from the Pandemic. At https://www.youtube.com/watch?reload=9&v=pMN8KZ1dPO8.

[8] El Omrani et al. report that 329 medical schools in 92 countries have formal education on the topic of health impacts of air pollution in the curriculum.

> 1) environmental change significantly impacts the diseases that health professionals see and treat, 2). environmentally sustainable practices offer great opportunities to improve public health and health care services, 3) health services have a large ecological footprint, and 4) reducing this footprint, saving money and improving patient care can go hand in hand" (ibid. 191).

These four interdisciplinary rationales cover a spectrum of climate concerns in health care.

Learning objectives were then developed using a modified policy Delphi approach. The group initially proposed 10 learning objectives developed from key articles published between 2002 and 2012 discussing climate, the carbon footprint of climate change, and health impacts of climate change (ibid.). They discussed the:

> (a) content of learning objectives, (b) structure and presentation of learning objectives, and (c) methods for implementation (ibid. 193).

Content areas included simple definitions and background information on sustainability, climate change, and climate change health hazards. Topical areas of social significance were addressed—such as nutrition and food, pollution, population growth—as well as those with clinical significance, such as hospital management, including waste and procurement.

After three rounds of discussion, three learning objectives which aligned with the General Medical Council's (GMC) categories of doctor as scholar, doctor as practitioner and doctor as professional were proposed. They were:

- As a scholar, doctors require an understanding of how the environment and human health interact at different levels.
- As a practitioner, doctors must be able to apply knowledge and skills around sustainable healthcare in order to improve the environmental sustainability of health systems.
- As a professional, doctors must consider the ethical issues posed by the relationship between the environment and health.

Participants agreed that the delivery of the content should be flexible and tailored to the needs of the individual medical school, that is, either a single course on environmental topics or a "perspective" through which education is disseminated (ibid. 195).

Following this 2015 initiative, a 9-month collaborative project was launched to educate medical school professors and assess opportunities for integration of sustainability into the curriculum. Eleven medical school teams applied for the project, 8 were accepted, and 7 implemented the area of new content (Walpole and Mortimer 2016). The seven medical schools that integrated topics on environmental sustainability represent over 20% of the medical schools (n = 33) in the UK at the time (Medical Schools Council 2018). These participating schools implemented or augmented sustainability courses or included sustainability as part of an integrated curriculum. Overall, students welcomed the new and expanded content and implementation was smooth, however, the professors reported needing more training to feel confident in delivery (Walpole and Mortimer 2016). This pattern is reflective

of other environmental initiatives in medical schools; medical students are active in petitioning for sustainability ethics in their education,[9] while professors and administrators require more persuasion. In 2020, a study by the InciSioN UK Collaborative on the integration of "global health education" in medical school curriculum reported that of 30 reporting medical schools, 20 included "future impact of climate change on health and healthcare systems" as a learning objective, while 25 listed "environmental and occupational hazards and ways to mitigate their effects" as a learning objective (4–5). The growth in environmental topics in medical school education indicates a positive and long-lasting trend.

16.2.2 Climate Change Ethics in US Health Professional Education

In the United States, students are educated about climate ethics across interdisciplinary health professional degree programs. For instance, Dr. Rebecca Philipsborn at the Emory School of Medicine developed a virtual 4-week *Climate Change and Health* curriculum, which includes topics and syllabi to be implemented in her own, and other, medical schools.[10] New York University (NYU) offers a Masters of Arts in Environmental Bioethics and a 5-year MD/MA program, which has two tracks leading to the terminal degree (New York University School of Medicine n.d.). Although NYU expects most of their dual-degree students to enrol in the health ethics track, the fact that a major university has a degree dedicated to environmental ethics attests to the growing interest and continued relevance of the discipline. Likewise, Harvard Medical School (HMS) has a club dedicated to topics connected to environmental ethics. Harvard Students for Environmental Awareness in Medicine (SEAM) publish a quarterly newsletter and "collaborate with the Longwood (Boston) Green Campus Initiative on a number of projects to improve energy efficiency and recycling and to reduce waste among students and staff" (Harvard University Centre for the Environment, Student Groups n.d.).

In addition to the aforementioned programs at NYU and HMS, the American Society for Bioethics and Humanities (ASBH) Environmental Bioethics Affinity Group has informally reported that several members utilize an environmental framework in their ethics courses.[11] Jeffrey P. Spike, the former Rabbi Samuel E. Karff Professor at the McGovern Center for Humanities and Ethics in Houston, Texas added two hours on climate change and health for the public health and policy program.

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[9] E.g., see: Harvard University Center for the Environment, Student Groups: Students for Environmental Awareness in Medicine SEAM. N.D. At http://environment.harvard.edu/student-resources/student-groups.

[10] See: Medical Students for a Sustainable Future MS4SF, Guide to Climate and Health Curriculum Reform in Medical Schools. At:https://docs.google.com/document/d/1lwLv-PZXZTymWbPLTB3604dvnOvg2gKntIoBo7QH-6c/edit.

[11] Communication with the author, 2016.

Laurie Zoloth, Professor of Religious Studies and Medical Humanities and Bioethics at Northwestern University taught a class in the medical school geared toward discussing the impacts of climate change on public health and ethical responses to the problem. Cheryl Macpherson, a Professor and Chair in the Bioethics Department at St. George's University School of Medicine in Grenada has taught approaches to climate change in her introductory bioethics course that is required in the 1st year medical curriculum. Cristina Richie integrated a component on environmental bioethics into her Health Care Ethics course at Massachusetts College of Pharmacy and Health Sciences in Boston from 2014 to 2017.

As more socially-engaged students petition for environmental topics in medical school curricula, there will be increased movements towards climate education in medical and other health care professional schools. Still, there are many ways in which climate ethics may be adopted in health care curricula.

16.3 Practice Points: Implementing Climate Ethics in Health Professions Education

The American College of Physicians (ACP), the second-largest US professional association of doctors with 148,000 members, has officially recognized the threat of climate change and made policy recommendations in a formal Position Statement (Crowley 2019). They outline the wide range of health consequences of climate change, beyond the well-known issues of air and water pollution. The ACP acknowledge the role of the health sector in carbon emissions, and indicate that:

> physicians and the wider health care community have a major stake in addressing climate change, not only by treating patients experiencing its health effects but also by advocating for effective climate change adaptation and mitigation policies, educating the public about potential health dangers posed by climate change, pushing for a low-carbon health care sector, researching and implementing public health strategies, and adopting lifestyle changes that limit carbon emissions and may achieve better health. (Gurevich 2020, 128)

In both the UK and the US, as well as other international health professions schools, climate change must be part of ethics education.

16.3.1 Opportunities

Medical educators argue that:

> Health care providers require training on the connections between the climate, ecosystems, sustainability, and health and their responsibility and capacity in changing the status quo. (Teherani et al. 2017, 1386042)

Hence, there are two opportunities for further implementation of climate ethics into health professions curriculum: broad learning objectives, and flexible delivery methods.

16.3.1.1 Broad Learning Objectives

The learning objectives put forth in the UK medical school curricula are broad enough to house several relevant sustainability topics across health professions education. Health professions schools that wish to implement sustainability may emphasize the carbon emissions of health care, in addition to maintaining education on the health effects of climate change. The ethical rationale for climate ethics in medicine may be based on duty from a deontological ethical perspective—"do no harm"—or be based on the impacts of climate change—climate change health hazards—from a consequentialist perspective (Gomberg 1989). A deontological presentation of sustainability relies on the obligation of health professionals to reduce resource use and can draw on supportive philosophical concepts like medicalization (Szasz 2007), pathologization (Brinkmann 2016), and overuse of health care (Korenstein et al. 2012)—all of which have negative impacts on patients through disease burden (Shrime et al. 2015), stigma (Richie 2019a), and medical error (Makary and Michael 2016). A consequentialist presentation of sustainability, which highlights the negative impacts of resource use, might be more data-driven and suggest carbon reduction measures across medical lifecycles (Campion et al. 2015), individual medical procedures (Lim et al. 2013; Richie 2015), prescribing practices (Richie 2020a), and within hospitals (Ghersin et al. 2020; Richie 2018). Whereas deontological sustainability can make strong appeals to green bioethics (Richie 2019b), environmental bioethics (Potter 1971; ten Have 2019), and environmental ethics (England 1993), a consequentialist sustainability fits within public health (Haines et al. 2006), public health ethics (Kass 2001), and theories of climate justice (Shue 2014).

16.3.1.2 Flexible Delivery Methods

Since sustainability, environment, and health care are intimately linked, they can be connected with new and foundational topics. Content related to sustainability in health professions education may be delivered in an integrated format, or in an individual course. Probably, both need to occur for maximum efficacy. Integrated formats can connect with topics already present in the curriculum. One UK school, for instance, is linking climate, health, and migration health; another school is focusing on sustainability, clinical ethics, and the traditional discipline of law (Walpole and Mortimer 2016). Other direct connections may include a module on the Hippocratic oath and the principle of non-maleficence in the context of the professional obligation to reduce carbon emissions in health care (Health Care Without Harm n.d.). Minimizing carbon emissions in health care can be linked to ethical allocation of

medical and institutional resources (National Health Services Sustainable Development Unit 2009). Public health, preventative health, and social determinants of health are relevant for background discussions on climate change health hazards (Galvão et al. 2009). In this way, education on climate ethics may occur in each year of the degree program. The primary benefit of integrated sustainability education is topical reinforcement and comprehensive exposure.

It should not need to be the responsibility of a bioethics department or ethics instructor to disseminate such information, lest students fall into the trap of thinking sustainability is *only* about ethics when it is significant for professionalism and professional development as well. Integrated formats can also serve as a testing ground: concepts which are easily grasped or most relevant may be continued, while more obscure topics or ones that students do not find compelling can be withdrawn. The primary downfall of integrated sustainability medical education is the potential for superficiality. Moreover, faculty may need to educate themselves on climate and health and develop strategies for presenting environmental concepts within their core courses.

Sustainability in health profession education may also take shape in a foundational or elective course. A foundational course might address general topics such as Climate and Health, whereas an elective may address specific topics, such as Environmental Bioethics, Green Bioethics, Environmental Racism and Social Determinants of Health, or Economics of Health Care Carbon.[12] The benefit of a dedicated course is mastery of material. Moreover, a foundational course could cross multiple departments including epidemiology, bioethics, and public health, thus distributing the obligations for sustainable education. The major disadvantage of a core course in sustainable health is the lack of space—real or imagined—in current medical school curricula, whereas the primary drawback of an elective is lack of total student education which reinforces the existing problems of compartmentalizing ecology and medicine. As with other educational programs, the presentation of foundational concepts like sustainability in first year core courses, with refreshers throughout the years, as well as in-depth electives, affirms both the importance and relevance of sustainability in medical curriculum.

16.3.2 Challenges

Challenges will remain around adoption of climate change ethics within health professions education curricula. Whereas sustainability in UK medical schools is supported by the General Medical Council (2009) and National Health Service (National Health Service Sustainable Development Unit 2009), not all countries have organisational support for climate ethics. There are three challenges to climate ethics

[12] For additional course suggestions, see The Centre for Sustainable Healthcare, CSH Sustainable Healthcare Courses. n.d. At https://sustainablehealthcare.org.uk/courses.

in health professional education that need to be overcome: room in the curriculum, instructor confidence, and perceived irrelevance.

16.3.2.1 Room in the Curriculum

Negotiating room in the curriculum is clearly a barrier to implementation of climate ethics. Alterations or additions to curricula are almost impossible without administrative support, student enthusiasm, faculty willingness, and simple, but compelling, academic resources such as articles, books, powerpoint slides, charts, and sample syllabi to facilitate teaching (El Omrani et al. 2020; McKimm et al. 2020; Walpole et al. 2019). This can be overcome by partnerships between institutions and sharing of resources to reinforce the importance of sustainability in curriculum and set precedent for wider adoption of such topics.

16.3.2.2 Instructor Confidence

Educators in the allied health sciences who feel underprepared to address environmental sustainability may be reminded that they are not expected to be experts on all topics offered in education and that even in existing courses, they had to at one point familiarize themselves with new theories, applications, or techniques in order to maintain relevance for students. Resources on environmental topics, from peer-reviewed literature, to advanced research fellowships such as those offered at the Centre for Sustainable Healthcare in specialties including nephrology, psychiatry, dental, public health, general practice, ophthalmology, education, anaesthesia, quality improvement, and surgery[13] are available for educators. Once educated, physicians can provide education to peers through Grand Rounds (Magdo et al. 2007), on-the-job training, and continuing education courses. Physicians can also lead by example, both outside and within the classroom as advocates of environmental ethics.

16.3.2.3 Perceived Irrelevance

A change in health care culture, which priorities sustainability in everyday life, would be a prerequisite to expanding topics in sustainability to educators and students (Richie 2020b). While students have spearheaded efforts to place sustainability

[13] See: The Centre for Sustainable Healthcare. n.d. Home- Who We Are-Fellows and Scholars. At https://sustainablehealthcare.org.uk/who-we-are/fellows-and-scholars.

into medical school curricula, some students may resist changes in curriculum or find environmental issues irrelevant (Walpole and Mortimer 2016). The extent to which student opinion should dictate alterations—either additions or subtractions—in curricula is contested, particularly when they might have epistemological reasons for rejecting sensitive topics like diversity and inclusion, bias, or, indeed, climate change. One approach to dealing with student resistance to the latter is simply to affirm broader institutional statements on sustainability—such as the ones by the World Medical Association and the American College of Physicians—and reinforce the aspects of professionalism, ethics, and health that underpin courses or lectures. The conventional wisdom of medicine, which tends to "focus on treatment over prevention" must be re-evaluated (Walpole et al. 2019, 6). Prevention is more sustainable than treatment (Richie 2019b) and is in the best interest of the patient, as well.

16.4 Conclusion: A Call to Include Climate Change Ethics in All Health Professions Education

Efforts to integrate sustainability into health professions education have international support. The World Medical Association (2009) recognizes that students need to understand climate change in the context of health. Moreover, in 2020, the International Federation of Medical Students' Associations (IFMSA), which represents 1.3 million medical students in 133 countries (IFMSA, n.d.) drafted a "Vision of Climate Change in Medical Curricula" (IFSMA 2020). Currently, 129 of the 133 countries represented by the IFMSA have adopted the document (El Omrani et al. 2020). Climate ethics in health care curricula is—and will be—a requirement of preparing students for their role as health professionals. Indeed, there have been an increasing number of calls for sustainability in medical schools (Tun 2019; Vujcich et al., 2020), dental education (Duane et al. 2017, 2019), and nursing (Lori and Madigan 2020; Lausten 2006; McNeill et al. 2020).

Ultimately, sustainability should be taught in all health care education, not only in the countries that are most responsible for pollution—such as the US and UK (Pichler et al. 2019)—but also those countries emerging in the global health care industry. Carbon emissions do not stay within national borders (Costello et al. 2009); all countries have a vested interest in educating medical students about sustainability, and the environmental impact of medical care, thus leading to changed practices—and changed practitioners (Table 16.1).

Table 16.1 Practice points

1	Broad learning objectives allow for maximum alignment with other core and elective courses
2	Flexible delivery methods give instructors latitude to integrate climate change ethics in their courses and practicums
3	Finding room in the curriculum for climate change ethics can benefit from "piggybacking" onto topics that are already covered, like ethics and public health
4	Instructor confidence can be built through self-education as a matter of professional development
5	Perceived irrelevance of climate ethics can be addressed by appealing to broad institutional support

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Chapter 17
The Philosophy of Technology: On Medicine's Technological Enframing

Benjamin Chin-Yee

17.1 Introduction: Questioning Medical Technology

In 2012 IBM,[1] in partnership with Memorial Sloan Kettering Cancer Centre, announced the development of Watson for Oncology, a supercomputing initiative which applied Artificial Intelligence (AI) to solve one of modern medicine's biggest challenges: how to effectively treat patients with cancer. Watson for Oncology, marketed as a clinical decision-support system, analyses Big Data—from medical records, pathology and imaging reports to the vast research literature and clinical practice guidelines—to recommend the 'best', personalized treatment for a given patient. Following this announcement, IBM formed partnerships with major cancer centres and health systems around the world in pursuit of its goal to revolutionize cancer care. Ultimately, however, Watson for Oncology did not achieve its aim, facing mounting criticisms over inaccurate recommendations, lack of sensitivity to local context, and overreliance on opinion of American experts (Tupasela and Di Nucci 2020). Yet despite these criticisms, as well as an ongoing paucity of evidence that the tool improves patient care, the project was an integral part of IBM's Watson Health division (2022).[2]

Over the past decade, enthusiasm for AI in medicine has only grown, and AI's ability to offer technological solutions for a wide array of clinical problems now seems boundless. Watson for Oncology is just one high profile example amongst a myriad of AI applications in healthcare, which range from interpretation of diagnostic

[1] International Business Machines Corporation, an American multinational technology corporation.

B. Chin-Yee (✉)
Division of Hematology, Schulich School of Medicine and Dentistry, Western University, London, ON, Canada
e-mail: benjamin.chin-yee@lhsc.on.ca

Rotman Institute of Philosophy, Western University, London, ON, Canada

[2] Since the time of writing, IBM has sold its Watson Health data and analytics business.

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testing to prediction of clinical outcomes and treatment recommendation (Topol 2019). Exuberance for medical AI has been met with concerns over epistemic and ethical problems posed by these technologies (Chin-Yee and Upshur 2019), including issues of bias, transparency, accountability, and trust, which link to more general debates in the ethics of AI (for examples, see Dubber et al. 2020) Engagement with these philosophical issues is of increasing relevance in health professions education, which must continually adapt to medicine's rapidly evolving technological landscape and reckon with the resulting impact on clinical training and professional identities.

This chapter raises a more fundamental philosophical question prompted by these recent trends: to what extent are the problems of medicine—that is, the problems that we train clinicians to address in practice—amenable to technological solutions? Put differently, how did medicine arrive at a point where clinical judgment, once a paragon of human reasoning, became something that might be best performed by a machine? While such questions are not new—indeed, critiques of biomedicine's 'technological imperative' are longstanding (for example, see Burger-Lux and Heaney 1986)—recent developments in Big Data and AI give new impetus to address these questions and revisit the role of technology in medicine today. To this end, this chapter undertakes a foray into the philosophy of technology to extract relevant insights for health professions education.

I begin by discussing the relationship between science and technology and introduce the commonplace positivist view of technology prevalent within the medical profession. This is followed by a selective survey of approaches in the philosophy of technology, focusing on critical accounts by three philosophers from distinct periods and intellectual traditions, Martin Heidegger (1889–1976), Andrew Feenberg (1943), and John Dewey (1859–1952). I highlight how these philosophers challenge received views on the place of technology in modern society and offer particularly relevant insights for questioning medical technologies. This discussion emphasizes three key themes for health professions education while dispelling three myths of the positivist position: first, technology does not simply refer to material artifacts but describes a particular way of thinking and interacting with the world; second, technology is not value-neutral but rather reflects a range of social choices and human values; and third, technology does not serve as pure means to fixed ends but instead exists as a continuum of evolving means and ends. By introducing readers to key issues in the philosophy of technology, my aim is to support reflection and critical engagement amongst clinicians, educators, researchers, and trainees with the technologies that increasingly play a pivotal role in clinical practice.

17.2 Art, Science, or Technology?

Is medicine an art or a science? This oft-repeated false dichotomy, while debunked by a number of scholars (for examples, see Montgomery 2005; Whitehead and Kuper 2015; Fuller 2015; Solomon 2015), seems to hold continued traction amongst

students and healthcare professionals today. Perhaps this is because it gives expression to a particular uneasiness with medicine's irreducible uncertainties felt especially amongst healthcare professionals whose training disproportionately focuses on medical 'science', where 'science' continues to be understood in narrow, positivist terms, as the privileged mode of access to value-free facts about the world. Preserving the category of 'art', encompassing and nebulous, ensures that all of medicine's uncertain elements—from intuition and emotion to ethics and values—can be neatly cordoned off from its more 'scientific' base. This perspective still leaves the path open for medical science to gradually work away at these uncertainties, with the hope that the vagaries of 'art' will soon become relics of a bygone era, the stuff of Hippocrates and Osler but not befitting the contemporary clinician equipped with modern science and its technological affordances.

There is a grain of truth in this slightly hyperbolic narrative about scientific medicine. Positivism and foundationalism are alive and well in medicine today (See Chap. 13 for an overview of this state of affairs). One example is provided by the Evidence-Based Medicine movement (for discussion, see Bluhm and Borgerson 2011), which sought to establish clinical epidemiology and its tools as medicine's new 'base'—the new "basic science for clinical medicine" (Sackett 2005). Such views continue to inform more recent data-driven, quantitative approaches, including medical AI, which promise to bring us closer to 'truth' in diagnosis, prediction, and treatment decisions (Chin-Yee and Upshur 2018, 2019). While there is a tendency to classify these developments as advancements in the science of medicine, which remains the emphasis of health professions education, these latest trends also highlight medicine's growing technological dimension. Making sense of these trends and their meaning for the medical profession, therefore, requires that we ask: what is the relationship between medicine's science and its technologies?

According to the received view, the answer is straightforward: technology, simply put, is applied science. Medical technologies, therefore, are the application of medical science. Science teaches us how the immune system functions; vaccines are technologies which leverage that understanding to prevent disease. Science tells us how cells divide and proliferate; cancer therapies are technologies that exploit this knowledge to abrogate the process. What I have just introduced can be termed the positivist view of technology, a commonly held perspective that serves as a foil to the critical approaches discussed below. The positivist view of technology follows from its view of science. By this account, 'pure' science involves the pursuit of theoretical knowledge, which is value-free, ahistorical and universal; technology is the application of this theoretical knowledge towards the efficient attainment of practical ends.

Three features of the positivist view are worth noting here. Firstly, it is hierarchical: science precedes technology, with scientific knowledge forming the basis of technological innovation. Technology develops as a result of advancement in science and its disinterested pursuit of theoretical knowledge. Secondly, while technology is directed at practical ends, these ends are extrinsic to technology itself which exists as 'pure means' to attain predefined ends in the most efficient and rational manner. This view of technology as 'pure means' to an ends is sometimes referred to as naïve

or "straight-line" instrumentalism by its critics (Hickman 1990; Winner 1978). By this view, technology is value-neutral: although it aims at practical ends, which may be socially defined according to various interest and values, considerations of design and function are purely technical and scientifically determined. Thirdly, given that technology is a direct extension of science and embodiment of its rationality, the positivist view confers upon technology a certain scientific legitimacy. For the positivist, science is our best, indeed our only, mode of access to true knowledge about the world, and this privileged status transfers to technology, whereby technology offers our best means of attaining practical ends in the world. Sometimes, this latter perspective is referred to as technological solutionism, or simply solutionism for short. That solutionism often follows from positivist views of science and technology is evidenced by how such arguments often emerge from society's most scientistic sectors, healthcare included. The rise of solutionism in health professions education in particular has recently come under scrutiny (Ajjawi and Eva 2021).

Needless to say, positivism has encountered a multitude of challenges, both in terms of its views of science and technology. On the one hand, its view of science faced significant criticism by post-positivist philosophy of science. Review of these criticisms is beyond the scope of this chapter (for background, see Chap. 13), but a major source came from historians and practice-oriented philosophers of science, who helped dispel the myth of 'pure' science by examining the historical and social conditions that influence the production of scientific knowledge. Of relevance to our discussion, such analyses revealed the bidirectional relationship between science and technology, challenging the hierarchy moving from 'pure' science to applied technology. To cite just one example from the history of medicine, Louis Pasteur's research in microbiology, while often rationally reconstructed as 'basic' experiments providing proof of a germ theory of disease, were in fact part of a broader research programme that relied upon a state-of-the-art laboratory technology, as well as knowledge gained from applied processes of fermentation in the brewing industry and agriculture (Latour 1993). A plethora of historical and contemporary case studies bring into question the priority of science over technology, to the extent that some scholars now prefer 'technoscience' as a more descriptive term for the amalgam that constitutes modern day research (Pickstone 1993). On the other hand, the positivist view of technology, together with its instrumentalist and solutionist perspectives, have been the focus of significant criticism in the philosophy of technology, which I explore in the next section.

17.3 Lessons from the Philosophy of Technology

Philosophy of technology is a growing discipline which has attracted scholars from a number of different intellectual traditions and orientations. While philosophical engagement with technology has its roots in antiquity (for discussion, see Franssen et al. 2009), contemporary philosophy of technology emerged from attempts to

reckon with the growing presence and influence of technology in modern society. As the field expanded it became roughly divided between scholars more interested in questions of design and function of technical artifacts in themselves, often from backgrounds in engineering and analytic philosophy of science, and those occupied with the broader social and existential impacts of technology, often from backgrounds in the humanities and social sciences. The latter is sometimes dubbed the "humanities philosophy of technology" to contrast the "analytic philosophy of technology" (Mitcham 1994). Although this division is imperfect, and many philosophers (including Dewey) do not clearly fit within one side, this introduction will focus mainly on scholars from the so-called humanities tradition, who, by addressing the human and social dimensions of technology, offer insights of particular relevance to health professions education. One entry point into this literature can be found in the work of Martin Heidegger, whose *The Question Concerning Technology* ([1954] 1977) serves as a seminal text for the field.

17.3.1 Heidegger's Question Concerning Technology

To understand Heidegger's philosophy of technology we must first situate it within his broader philosophical project. The central question for Heidegger's philosophy is the question of being. His most celebrated work *Being and Time* ([1927] 1996) is a study of the fundamental nature of human existence or "being-in-the-world". Heidegger challenged Western philosophy's dominant interpretation of human existence as 'spectators' perceiving neutral objects in an external world. Rather, according to Heidegger, we find ourselves "thrown" into a world, already interpreted and imbued with meaning and significance. In a sense, being-in-the-world can be understood as practical in its orientation; objects do not appear to us as simply objects, but rather stand "ready-at-hand", situated within our larger projects and goals, with immanent meaning through their embedding within specific interpretive contexts. To give an example, Heidegger writes of how when we perceive a table in a room, what we perceive is not simply a neutral object, extended in space with specific dimensions and properties, but rather *this* particular table, which may be a *table-for-writing*, a *table-for-dining*, and so on. Moreover, our interpretation of this table is not just personal and idiosyncratic but also incorporates broader historical and cultural valence, felt, for example, when we perceive our old student's desk in our grade school English classroom, or the antique harvest table in our family home. In this way, for Heidegger, being encompasses a mode of disclosing the world—a mode of "revealing" it to us in existence.

Heidegger's philosophy of technology follows from this interpretation of being. Technology for Heidegger cannot be understood in narrow, instrumentalist terms, as value-neutral means to an end, but rather constitutes a mode of being—a mode of revealing the world. As mentioned, Heidegger was a critic of Western metaphysics and the resulting outlook of modern science, which objectifies the natural world.

But rather than technology being the product of this scientific worldview, Heidegger reverses the relationship: the misunderstanding of being found in Western philosophy, and by implication in modern science, is a symptom of technology and its mode of revealing. Here Heidegger inverts the positivist view, asserting the ontological priority of technology over science.

What does Heidegger mean when he calls technology "a way of revealing"? Heidegger points out how technology engenders a particular outlook which shapes our being-in-the world. For example, he argues that through the technological outlook of modern mining and forestry we come to view the earth as a source of mineral deposit or the forest as a source of lumber—ordered "cellulose", as he calls it (Heidegger [1954] 1977). Through this way of revealing "everywhere everything is ordered to stand by". Technology brings about an "ordering" of the world where everything is seen as "standing-reserve". Heidegger refers to this as "enframing", through which "the work of modern technology reveals the real as standing-reserve". For Heidegger, enframing is the essence of technology: "The essence of modern technology shows itself in what we call Enframing". Enframing results in a flattening of the immanent meanings revealed by pre-technological being, and in this way threatens the very act of revealing itself. As Heidegger (ibid) writes:

> The coming to presence of technology threatens revealing, threatens it with the possibility that all revealing will be consumed in ordering and that everything will present itself only in the unconcealedness of standing-reserve (33).

Technology's way of revealing, however, is not limited to the natural world, but also threatens to encompass human beings themselves. Herein, for Heidegger (ibid.), lies the real danger:

> As soon as what is unconcealed no longer concerns man even as object, but does so, rather exclusively as standing-reserve, and man in the midst of objectlessness is nothing but the orderer of the standing-reserve, then he comes to the very brink of a precipitous fall; that is, *he comes to the point where he himself will have to be taken as standing-reserve* (emphasis added, 26–27).

Such a claim might seem unsurprising today, in a time when the datafication of day-to-day existence has become fact of life, serving as a reminder of the power of technological enframing from which human beings are not immune. This enframing is also seen in healthcare, where data-driven technologies effect an ordering of human bodies and their data, which 'stand-in-reserve' as inputs into algorithms. A full discussion of Heidegger's philosophy of technology and its applications to healthcare could fill a volume of this size. The key takeaway for our discussion is Heidegger's view of technology as a "way of revealing" that he calls "enframing", which for him captures the "essence of modern technology".

While Heidegger's writings on technology have been influential they are not without criticism. Although some critics characterize him as a Luddite or Romantic, nostalgically clinging to a pre-technological age, his arguments cannot be so easily dismissed. Heidegger ([1954] 1977) recognized that we cannot simply return to a former, pre-technological mode of being but rather argued that we must strive

to gain a "free relationship" with technology. Heidegger himself was notoriously obscure about how this might be achieved, and pessimistic about the prospects, (in)famously stating in his last interview with *Der Spiegel* "only a god could save us now" (Heidegger [1966] 2017). For this reason Heidegger is sometimes seen as a technological determinist, attributing to technology an autonomous power to inevitably shape humanity and the social world. Some interpretations of Heidegger attempt to move away from his determinism and its pessimistic conclusions, for example, offering the possibility of keeping touch with revealing through "focal things and practices" (Borgmann 1984, 16), or cultivating a plurality of modes of being which includes the technological (Dreyus and Spinosa 1997). Such approaches find parallels in health professions education, where some have advocated pluralism with respect to medicine's diverse 'ways of knowing' (Chin-Yee et al. 2018; Thomas et al. 2020). I will return to these ideas below but first introduce another philosopher of technology who attempts to overcome certain limitations of Heidegger's account.

17.3.2 Feenberg's Critical Theory of Technology

Andrew Feenberg is a contemporary philosopher of technology who integrates insights from both Heidegger and the Frankfurt School, especially Herbert Marcuse, to develop what he calls his "critical theory of technology" (Feenberg 1991, 2002). While Heidegger remains his starting point for critical reflection on technology, Feenberg challenges the essentialist and determinist interpretations found in Heidegger and other critical theorists, which tend to overstate technology's autonomy and power over the social world. Rather, Feenberg's account not only looks at how technology shapes society but also how society shapes technology. Here he draws on social constructivism, which examines how social norms and interests influence technological design and operation within 'sociotechnical' systems (for discussion, see Bijker et al. 2012).

Feenberg emphasizes the constructivist notion of technological underdetermination, which holds that considerations of function and efficiency alone underdetermine the design of technical artifacts, which necessarily require additional social choices. Feenberg cites a famous example from Langdon Winner's classic essay "Do artifacts have politics?" (Winner 1980), a question which is answered in the affirmative. Winner discusses how the low hanging overpasses of New York's Southern State Parkway reflect deliberate design choices by their architect, Robert Moses, who sought to exclude low-income and racialized groups that relied on buses to access Long Island's beaches. Winner's case study illustrates how a technical artifact, such as a bridge, is not politically neutral but rather can incorporate racist and classist ideologies in its very design. These ideologies, however, become concealed, inscribed as "technical code" during the artifact's production (Feenberg 2010b). "Technical codes" introduce bias, which can be "substantive", a reflection of societal prejudices, or "formal", arising from the very idea of what constitutes a rational, well-functioning system.

Several scholars offer examples of how design choices encode bias in technical systems, from search engines to insurance algorithms (for examples, see Benjamin 2019b; Noble 2018; Eubanks 2018). Medicine is also ripe with examples, with historians and sociologists exposing how what are commonly taken as neutral instruments can incorporate ideologies of race and gender, from the speculum (Sandelowski 2000) and spirometer (Braun 2014), to state-of-the-art predictive algorithms (Benjamin 2019a). While some might see these as extreme examples, it is important to note that all technologies have an inherently normative dimension written in their technical code, which dictates factors such as which users are included/excluded and how a technology operates within a given social order. To again use the example of vaccine design, factors such as appropriate storage conditions, means of transportation, number of doses required and dosing interval, all might have technical and scientific rationale, but they are also normative, shaping how vaccines are 'properly' used, who has access, and who does not.

Bias, therefore, is a basic feature of all technical systems, which one uncovers by interrogating the co-construction of the technological and the social. According to Feenberg, technology does not simply entail, as it does for Heidegger, a "way of revealing" the world as decontextualized objects, the "standing-reserve", reduced to functional utility (Heidegger [1954] 1977). Rather, technology must also undergo a "secondary instrumentalization", which reappropriates context, giving an artifact its social meaning and adding additional normative content (Feenberg 2002). For Feenberg, this process even has the potential to bring about a reconfiguration and transformation of technology according to human interests.

By bringing together critical theory and social constructivism, Feenberg generates a dialectic between instrumentalist and determinist perspectives: technology indeed shapes the social order but at the same time humans maintain their agency to change technology (for an in-depth discussion of agency, see Chap. 11). This allows him to propose a more optimistic account, wherein technology is not always oppressive but can instead serve as a medium for expression of social values, opening up the possibility of democratizing technical systems. To paraphrase Feenberg (2010a), it is through technology that today's values become the facts of tomorrow. This idea in particular brings Feenberg's philosophy of technology into close proximity with John Dewey's, which I turn to now.

17.3.3 Dewey's Pragmatist Philosophy of Technology

John Dewey is widely known as a philosopher of American pragmatism, whose near-century's worth of writing spanned topics from logic and epistemology to politics and education. Dewey is less commonly known, however, as a philosopher of technology, although there is growing recognition of his ideas on technology thanks to sustained efforts by scholars such as Larry Hickman (1990; 2001), as well as the

recent publication of a previously lost Dewey manuscript (2012). It is fitting to end our survey with Dewey, who ties together several of the themes discussed above.

Despite coming from distinct intellectual traditions, Dewey shares Heidegger's view of the ontological priority of technology over science. Also, similar to Heidegger, Dewey's ([1929] 1984a) view of technology is best understood within a broader critique of Western epistemology and its "spectator" theory of knowledge. For Dewey, even more so than for Heidegger, human existence is a practical affair: we are not spectators of nature, perceiving an external world from which we ascertain knowledge, but rather are active participants in it. Knowledge, therefore, is not a set of universal propositions but rather is context-dependent and directed towards a use or end—not simply knowledge but *knowledge-for*.

Dewey's conception of technology follows from this pragmatist perspective. For Dewey, knowing itself can be understood as a form of technology, where technology is roughly defined as a method of inquiry and set of tools for resolving problematic situations. This differs in an important way from Heidegger view of technology as a mode of revealing. Dewey offers a naturalized account of technology, which—contra Heidegger—is not a uniquely modern (mis)understanding of being, but rather a fundamental aspect of how humans cope with the natural and social world. Like Feenberg, Dewey also rejects Heidegger's essentialism: there is no 'essence' of technology or of the technological; technology instead describes both the process and product of inquiry, which is not fixed but rather evolves to fit context and human needs. As Dewey ([1930] 1984b) put it: "'Technology' signifies all the intelligent techniques by which the energies of nature and man are directed and used in satisfaction of human needs" (270).

While this definition might seem somewhat broad, Dewey's writings on technology are in fact subtle and multifaceted with deep links to his pragmatism, as explored in detail by Hickman (1990; 2001). For want of space, I will focus on one central aspect of Dewey's philosophy of technology, which is his treatment of means and ends. A first point to make is that Dewey rejected the notion of fixed ends or "ideals", which he argued had been emphasized in Western philosophy since antiquity. Rather, he sought to elevate means, which he believed had been wrongly denigrated as "menial" and subordinated to ends. A vestige of this view is perhaps contained in the positivist position, whereby technology serves as pure means, lacking any content beyond its function in attaining predefined ends. At the core of Dewey's philosophy of technology is the interdependence of means and ends. For Dewey, ends always arise during the process of inquiry, emerging out of a problematic situation that demands resolution. He uses the term "ends-in-view" to emphasize the provisional, revisable nature of ends, which should not be taken as fixed ideals (Dewey [1922] 2008). While ends-in-view form one component of inquiry, means play an equally important role in determining its course.

This interplay between means and ends is best illustrated by way of example. I am faced with a patient who is anaemic: my ends-in-view is to identify the source of blood loss, which suggests a means of investigation, for instance, endoscopy. This

produces a new end, namely, to stop the identified source of bleeding. This end, however, is not fixed or final; once achieved it must be re-evaluated within the new situation. For example, if the source of blood loss turns out to be a tumour, additional ends arise which in turn indicate new means for action. This case highlights what for Dewey is a general feature of human activity: ends are not extrinsic givens but rather emerge from within the context of inquiry. Across several of his writings, Dewey warned against pursuing "fixed" ends, which might be said—to paraphrase another American pragmatist—to block the path of inquiry (Peirce [1898] 1960).

What are the implications for healthcare? Dewey would be critical of approaches in medical research and health professions education that reify quality of care based on narrow metrics, such as adherence to specific guidelines or achieving particular biomarker targets, which impose fixed ends but often overlook their means and potential harms. Likewise, he would disparage medical technologies focused on preset performance targets to define success, such as a high area under the receiver operating characteristic curve for a machine learning model, which may indicate high sensitivity and specificity but does not attend to use within a wider clinical context and impact on patient-centered outcomes (for discussion, see Oren et al. 2020). For Dewey, ends must not be extrinsic, built into "off the shelf" technologies according to prevailing interests, but rather should arise from inquiry aimed at ameliorating the human condition, and therefore should be democratically instantiated (Waks 1999). Dewey (2012) rejects the positivist idea of technology as pure means to external ends, which renders technology "indifferent" to its uses, and "signifies that something else is sure to decide the uses to which it is put" (244). For Dewey, that "something else" included not only "traditions and customs" but also "rules of business", words written—not incidentally—during the Golden Age of American capitalism. This lesson remains especially salient today, amidst growing recognition of powerful commercial interests driving the technologization of healthcare, with advances in digital health technologies often coeval with shifts towards greater privatization (Wamsley and Chin-Yee 2021). Healthcare professionals must remain vigilant of where the ends of technologies derive, and ensure that providers, patients, and their communities are engaged in the co-construction of tools. Here Dewey, not unlike Feenberg and the social constructivists, shows us how ethical considerations and questions of values play a crucial role in the determination of technology's ends and means.

17.4 Conclusion: Technology and the Practical Art of Medicine

We are now in a better position to revisit the false dichotomy posed at the outset, that incalcitrant dualism between the art and science of medicine which has the propensity to devolve into arguments over medicine's "two cultures" (Wulff 1999; Snow [1959] 1993), maintaining an erroneous divide between facts and values. As

Kathryn Montgomery (2005) points out, medicine is best understood as a practice, or as Dewey might put it, a *practical art*.

This chapter has highlighted how medical technologies cannot simply be understood as extensions of medical science but rather form a fundamental part of medicine as a practical art. And as practical art, technology is one locus where facts and values come together, an idea supported by all three philosophers discussed above. I conclude by reiterating three main themes from this discussion, which help dispel myths of the positivist position and offer important lessons for health profession education. Each theme not only serves as a starting point for critical dialogue between medical educators and learners but might also be integrated into medical curricula as a basis for teaching on the ethical and social dimensions of technology, supplementing a tendency for technological education to focus on acquisition of discrete skills and competencies while often overlooking broader questions of context and application (Table 17.1).

17.4.1 Technology as a Way of Thinking

The first lesson, common to both Heidegger and Dewey, is that technology does not simply refer to material artifacts or "mechanical forms" but rather encompasses a way of thinking or being-in-the-world (Dewey [1930] 1984; Heidegger [1927] 1996). Applied to healthcare, this lesson occasions reflection on how technology and technological thinking shapes our 'ordering' of the clinical world and interactions with patients. It warns against a tendency to see patients as mere 'standing-reserve', reducing their experiences to data, which serve as inputs for use in algorithms (Chin-Yee and Upshur 2019). Healthcare professionals must be cognizant that these tools form only one mode of revealing, powerful yet limited. To truly support a 'free relationship' with technology, educators must create space for other forms of 'revealing', for example, by helping to cultivate those "moments of being" which give meaning to practice (Kumagai et al. 2018). Knowledge from the social sciences and humanities, including philosophy, can help foster this epistemic humility and pluralism with respect to medicine's "ways of knowing" (Chin-Yee et al. 2018; Thomas et al. 2020). This lesson avoids training healthcare professionals who are technically proficient at gathering data and applying algorithms but who are unable to step outside this mode of revealing to see a clinical problem from a different angle or appreciating another perspective not captured by the algorithm.

17.4.2 Technology as Value-Laden

The second lesson, found in all three thinkers, recognizes technology not as the value-neutral application of science but rather as "teeming with values and potentialities"

(Hickman 1990), which reflect a range of social choices. This lesson in particular requires us to examine those choices and the biases they encode. It raises critical questions, such as 'Who is included?', 'Who is excluded?', and 'Whose interests does a given technology serve?' Such questions should be continually raised in medical research and health professions education, serving as opportunities to reconfigure and transform technology's means and ends, orienting them towards greater equity and inclusion.

17.4.3 Technology as a Continuum of Means and Ends

The last lesson is that technology does not exist as pure means dictated by external ends but rather involves a continuum of means and ends, which develop iteratively through the process of inquiry. This lesson teaches that technology's ends are fallible, and alongside means, require revision and adjustment to context.

Returning finally to the opening example of Watson for Oncology, performance of such a tool cannot be evaluated solely on the basis of pre-defined ends, such as agreement with expert consensus as is often the case in appraisal of algorithmic decision-making (Tupasela and Di Nucci 2020). Rather, it requires that we situate the technology's use within the uncertain situation *in its totality*, in this case, the clinical problem of selecting treatment for a patient with a diagnosis of cancer. From here we ask: 'What are the ends-in-view?' Such a question focuses the problem: Is it to provide the 'best' treatment as defined by the latest clinical trial evidence? Is it to tailor 'precision' therapy for a specific set of genomic biomarkers? Or, rather, is it to treat *this* particular person in a way that considers their individual context and values? Such ends differ in important ways and suggest different means, calling for different tools or even different modes of thinking altogether.

Healthcare professionals must remain sceptical of approaches that reify ends, defining success in narrow terms, and instead indefatigably scrutinize means and ends for their ability to serve the needs of clinicians, patients, and their communities. In this endeavour clinicians, educators and philosophers all play a critical role, offering the knowledge and values to shape the medical technologies of tomorrow. The rapid pace of technological change can be overwhelming for many, giving rise to a tendency to relinquish control and adopt a determinist perspective—recalling Heidegger, that "only a god can save us now". However, to end on a more optimistic note, we might also reflect on a quote from Dewey ([1934] 2013), who argues for a different type of faith:

> Faith in the power of intelligence to imagine a future which is the projection of the desirable in the present, and to invent the instrumentalities of its realization, is our salvation. And it is a faith which must be nurtured and made articulate: surely a sufficiently large task for our philosophy (48).

Table 17.1 Practice points

1	Philosophy of technology teaches us to think critically about medical technologies and offers important lessons for health professions education
2	Technology does not simply refer to material artifacts but instead describes a particular way of thinking and interacting with the world
3	Technology is not value-neutral but rather reflects a range of social choices and human values
4	Technology does not serve as pure means to fixed ends but instead involves a continuum of means and ends which evolve through the process of inquiry
5	These lessons support more reflexive engagement with technology amongst healthcare professionals to better address the needs of clinicians, patients, and their communities

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Chapter 18
Philosophy as Therapy: Rebalancing Technology and Care in Health Professions Education

Martina Ann Kelly, Tim Dornan, and Tinu Ruparell

18.1 Introduction: Contradictions in 21st Century Health 'Care'

The best physician is also a philosopher

Galen, Title of a Treatise (165–175 BCE).

Fildes' painting of 'The Doctor' (1891; See Fig. 18.1) at the bedside of a sick child epitomises a type of caring that centres on a patient and their family. Fildes' moment, frozen in time, is used to stimulate medical students to discuss doctor-patient relationships (Macnaughton 2000; Olthuis and Dekkers 2003; Tauber 2000; Verghese 2008). How often, we might ask, does contemporary practice conform to that epitome? Much of it is delivered in sterile spaces, bustling with members of different professions and bristling with technologies intoning an anthem of beeps. Steel trolley-beds in wards have taken the place of wooden beds in patients' homes and, during the COVID-19 pandemic, personal protective equipment covers conventional attire. The term 'healthcare' has become more organisational than charismatic, with overtones of electronic medical records integrated with laboratory networks, diagnostic imaging, and targeted, precision medicines. Artificial intelligence heralds an era when even wisdom is to be instrumentalised. Healthcare is morphing into a landscape of trade and policy where bureaucratization and mechanisation subsume, dilute, objectify,

M. A. Kelly (✉)
Cumming School of Medicine, University of Calgary, Calgary, AB, Canada
e-mail: makelly@ucalgary.ca

T. Dornan
Queen's University Belfast, Northern Ireland, UK

Maastricht University, Maastricht, The Netherlands

T. Ruparell
Department of Classics and Religion, University of Calgary, Calgary, AB, Canada

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Fig. 18.1 Fildes' painting of 'The Doctor'

and quantify people's individual experiences of care. Health professions education, meanwhile, espouses caring as its foundational value (Fig. 18.1).

Putting our current practice of highly complex and abstract technological healthcare 'back in the box' is not a realistic option, so the aspiration to stay true to caring values demands urgent reconsideration of what we mean by technology. According to Heidegger (1962), the old High-German word *Sorge* equates caring with 'being there' or Dasein. Addressing Heidegger's 'question of care' requires us to interrogate what we understand *as technology*. *Sorge* gives us a philosophical means to reveal or situate physicians and patients in ways that shed light onto how health professions education and practice can be caring. The purpose of this chapter is to examine how *philosophy, as a technology of care,* can disentangle the complex interrelationships between caring, technology, and healthcare in ways that help us see patients, students, clinicians, and practice anew. We use the term 'caring' to mean relationships imbued with the core values of clinical practice, as described above, and 'care' to refer to the system within which these caring relationships may take place.

18.2 Historical Precedents

Galen's dictum that the best physician is also a philosopher, which heads this chapter, provides a prompt from the second century BCE to explore the philosophy of caring and technology. It justifies, also, our quest for a philosophical care: a *therapeia*

or *philosophical therapy* that can combat suffering. Our next figure, who lived in the sixth century BCE was the Roman statesman and philosopher Anicius Manlius Severinus Boethius. A dialogue composed by Boethius (as he is commonly known) entitled *The Consolation of Philosophy* (Boethius [523] 2000) was one of the most influential books of the European long middle ages. At the beginning of the text, the imprisoned Boethius laments his fate and, indeed, his continued existence when he is visited by *Lady Philosophy*:

> a woman of a countenance exceeding venerable. Her eyes were bright as fire, and of a more than human keenness; her complexion was lively, her vigour showed no trace of enfeeblement; and yet her years were right full, and she plainly seemed not of our age and time … Her right hand held a note-book; in her left she bore a staff. (16–17)

Boethius, blinded through his tears, is struck dumb by this vision. Lady Philosophy responds as a physician, saying to him that the time "calls for healing rather than lamentation […],

> Then, when she saw me not only answering nothing, but mute and utterly incapable of speech, she gently touched my breast with her hand, and said: There is no danger; these are the symptoms of lethargy, the usual sickness of deluded minds. For a while he has forgotten himself; he will easily recover his memory, if only he first recognizes me. And that he may do so, let me now wipe his eyes that are clouded with a mist of mortal things. Thereat, with a fold of her robe, she dried my eyes all swimming with tears. (22–23)

Boethius remembers her, from his time as a youth:

> … even so the clouds of my melancholy were broken up. I saw the clear sky and regained the power to recognize the face of my physician. Accordingly, when I had lifted my eyes and fixed my gaze upon her, I beheld my nurse, Philosophy, whose halls I had frequented from my youth up. (24)

So began the tradition of philosophy as a healer (or rather healing), and carer (caring). As the second text shows, the *mere presence* of Lady Philosophy was a powerful therapeutic effect on Boethius. The next section moves from those early precedents to a modern articulation of a philosophical discipline: hermeneutics.

18.3 What Is Hermeneutics?

Hermeneutics, put simply, is the theory of interpretation. Historically, religious texts were the object of hermeneutic inquiry, but hermeneutics has later applied to general questions of interpretation per se and, more specifically, the interpretation of experience. This rendered an alternative account of human understanding, reflection, and subjectivity to the explanatory model of natural sciences. Hermeneutics seeks to reveal, clarify, and critique conditions which give rise to discourses, beliefs, and practices through which we engage with the world and each other.

The entry point for hermeneutic inquiry is often a fissure: an experience that catches us and makes us pause; (Moules et al. 2014) for example, I (Martina) started

to write this chapter feeling confident about my understanding of care. As I reflected on my experiences during the COVID-19 pandemic, I recognised new insights and interpretations that troubled me. These led me to question what *is* care, rather than 'what should care be', or 'what does healthcare understand care to be'. Pursuing questions like mine presents us with 'texts', which means any linguistic, symbolic, or experiential expression of meaning which presents us with the primordial question: "what am I?" Our response is to construe the text; to interpret it *as* something. This very *construal-as* transforms the text into something new, which prompts new questions. The hermeneutic dialectic invites us into a circular process of describing and interpreting through which things reveal themselves.

Through the hermeneutic circle, a thing reveals itself *as* what we are coming to understand: it homes in, spirally, towards a tentative and temporary 'reading', whilst simultaneously revealing a plethora of other possible *construals-as*. The product of a hermeneutic circle is not an absolute endpoint but a temporary stopping place; a moment of respite on a potentially unending journey of discovery.

While hermeneutics is just one possibility among several philosophical practices, it provides useful ways of opening a deeper inquiry into caring. It supports a practice of questioning, which springs from the natural propensity within us all to reflect rationally on our experiences of engaging with the world (Gadamer 1981).

18.4 Applying Hermeneutics

A key premise of our proposal that healthcare can be understood as a philosophical practice is that caring is a specific way of relating to and questioning another human being. It is *an intersubjective exchange between a patient and their physician, which reveals the particular, situated ways of being human of both patient and physician.* The work of two German philosophers, Hans-Georg Gadamer (1990–2002) and Martin Heidegger (1889–1976), helped us explore this premise by spirally interweaving hermeneutic ideas with our experiences as clinicians, researchers, teachers, and patients.

Heidegger's work helped us mitigate the dominance of technology by repositioning human experience at the centre of healthcare and health professions education. His concept of *mitsein,* being-with patients in the context of *therapeia,* supported our development of a *hermeneutic* understanding of patient-physician relationships, which took into account the context, role, and practice of interpretation. Gadamer's philosophical hermeneutics, founded on the core concepts of language and tradition, supported our examination of how dialogue between physicians and patients can foster understanding, explaining, and fusing horizons. Hermeneutics helped us destabilise the meaning of care in the very act of delivering an interpretation of care. This could only be a provisional interpretation, however, since, in Gadamer's words, '*interpretation is always on the way'* (Gadamer 1981).

18.5 Language

If meaning is shared and emergent, the medium through which this happens is particularly significant for interpretation: language manifests our understanding of a disclosed, shared world (Gadamer 2008). Gadamer viewed language as not merely a vehicle for understanding but as its very manifestation, part and whole. Words are, of course, part of a tradition which changes over time. As human beings, we inherit a linguistic tradition, a treasure trove of meaning bearing the marks of history, culture, and the meaning-making of people who preceded us. Language provides a semantic network which subtends a particular set of meaningful distinctions providing a structure through which the world is made intelligible (Simpson 2021, 4). Language, while not a mirror, is coextensive with the world and forms its manifest semantic articulation. Both language and our particular forms of life are meaningful in and through their relationship: "in language, experience and knowledge become sedimented and speak directly to us through the words themselves" (Gadamer 1996).

Understanding, as mediated by language, is not something we acquire and possess but something in which we participate: a way of being in the world. We live in a tradition of understanding; but, like fish who are unaware of water, we are hardly aware of the air we breathe. Attentiveness to language helps us unearth meaning, open possibilities for interpretation, and reveal forms of life as such. Anticipating, exploring, and playing with meaning, creates many possibilities. Importantly, too, this can show us how some interpretations abide and evolve, while others are lost; what is said/known is always in relation to what is unsaid and unknown. For Gadamer, each encounter with language is not a simple matter of unselfconscious appropriation and assimilation, but a thoughtful exercise of historical consciousness. Words provide transformative awareness of the shape of our being. This consideration of language in hermeneutics leads us, in the next section, to problematize care by deeply questioning some common language that underpins it.

18.6 Hermeneutic Reflections on the Language of Care *on Health, Illness, Healing* and Implications for Care

Susan Sontag famously wrote "everyone who is born holds dual citizenship, in the kingdom of the well and the kingdom of the sick" (Sontag 2001, 3). Illness cannot not exist without health. But what is health? Defined biomedically, as contemporary healthcare is wont to do, health is an ideal blood pressure, cholesterol level, and Haemoglobin A1c. Technologies that achieve targets defined by evidence-based guidelines determine citizenship of the kingdom of the well. This citizenship is at a premium as we extend disease definitions, screen for risks, and label what were previously considered ordinary human experiences as diseases. Those clinical activities *order* the experiences of both patients and clinicians. As Heath (2019) writes: "we have allowed tests to displace listening, numbers to displace description, technology

to displace touch, the objective to displace the subjective" (78). The World Health Organisation (WHO) definition of health is not merely the absence of disease but a state of complete physical, mental and social well-being (World Health Organization 1946). This sense of health as harmony-in-well-being sometimes escapes our attention and always the attention of our technologies of measurement. Health illustrates the "miraculous capacity we have to forget ourselves" (Gadamer 1996, 96). At least as far as this chapter is concerned, health is a condition of inner accord, a coherence with oneself, which cannot be determined by external forms of control (Ibid).

Illness disrupts the harmony of feeling well and being able to engage actively in the world. It does not represent merely a medical-biological disruption, but an experience of life-historical and social disconnection. The sick person is no longer the person she or he was before. They have become "unstuck" from themselves, having fallen out of their normal place in life and requiring support to re-establish equilibrium (Gadamer 1996, 42). Illness changes our identity, intimates mortality, and calls into question our being: the elusive essence of what it means to be human. Caring, as *Sorge*, originally meant to grieve, feel concern, or experience anxiety. When we fall ill, caring recalls our form of life and reconstitutes a way of being from which we (hopefully only temporarily) stumbled. Caring is a concern about who we are and who we want to be. Caring for our own health is an original manifestation of human existence (Gadamer 1996).

Gadamer regards the human task of healing, restoring the totality of our being-in-the-world, as dwarfing the science of illness (Gadamer 1996). To consider the role of treatment, Gadamer revisits the German language, where 'treatment' (*Behandlung*) and 'handling' (*handhaben*) are etymologically related. Caring is *handhaben.* It stems from the skilled and gentle hand of the physician-philosopher, who recognises problems by feeling affected parts of the body, while training a sensitive ear to what the patient says and observing them with an unobtrusive eye. Recalling Lady Philosophy, she begins her care of Boethius by saying, "*speak out, hide it not in thy heart. If thou lookest for the physician's help, thou must needs disclose thy wound"* (Ibid, 28, emphasis authors' own). Observing Boethius' fragile, weakened state, she chooses an initial course of action:

> Since thou art distraught with anger, pain, and grief, strong remedies are not proper for thee in this thy present mood. And so for a time I will use milder methods, that the tumours which have grown hard through the influx of disturbing passion may be softened by gentle treatment, till they can bear the force of sharper remedies. (Ibid, 42–43)

Many patients and physicians are aware that over-reliance on technology can be at the cost of caring. Physical examination, for example, can be more than a diagnostic procedure. It is an embodied interaction, which can express concern and presence. It is a bearing witness to illness, and a co-revealing of both the patient's and physician's form of being in the world at that moment. (Kelly et al. 2019).

Treating illness commands our attention to the totality of another person. *Healing* means 'making whole': not only a successful struggle against illness but caring, in its broadest sense, for a person (Gadamer 1996). Whole refers to the harmony: the interconnectedness of being a human in the world who is linked to others, caught in the

flux of experience, partners in a shared life-world. Healing, in this sense, recognises the simultaneous individual and communal nature of being. Healing relationships recognise the other in their otherness and defy care being 'standard'. Recognizing the other may guide us towards helping them find their own, independent way. It may help us discharge our responsibility both to be caring and to uphold the freedom of a patient. Healing thus gives space to the expression of self, as a being in the world, which allows physician and patient to acknowledge their similarities and differences. Caring, broadly speaking, is recognising a fundamental human concern about who we are and who we want to be. Caring, to summarise our philosophical-hermeneutic exploration, is much more than the instrumental application of 'compassionate competence' to a passive, vulnerable recipient of care—a patient. It is, rather, to understand the person, their illness and our relationship with them in the broader light of their broader flourishing.

18.7 Philosophy as a Technology of Care

We now consider how, like Lady Philosophy, we might deploy philosophy *as* caring. To be specific we examine technology from a philosophical viewpoint, considering how this could redescribe it as consistent with *therapeia.* To do this, we distinguish technology as a collection of tools, processes, instruments, and other contrivances, from a broader understanding of it to make space for philosophising as care.

No recent thinker has influenced our understanding of technology more than Martin Heidegger. In his short essay of 1954, *The Question Concerning Technology* (Heidegger [1954] 1977),[1] he argues three fundamental points. First, that technology does not refer merely to instruments. It is much more: a way of being in the world. Second, he proposes that technology is not something we humans make: it pre-exists us and we become caught up in it. Finally, he warns us of the beguiling, ensnaring power of technology and points to a deeper understanding, which both explains technology and, by doing so, shrugs free of its fetters. It is this third proposition that offers a practical role for philosophy in healthcare.

The key characteristic of technology for Heidegger, its essence, is that it *renders* or enframes the world in certain ways for us. For instance, picking up a hammer renders the world as potential nails. And the hammer also renders *us*: we become 'hammer-users' and are thus enframed by a technology that we deploy. In this sense, enframing is a natural and unavoidable aspect of technology. However, overreliance on the instruments of contemporary healthcare renders both patients and physicians as mere cogs in the bureaucratized machine of technologized practice, squeezing out possibilities for authentic action and concern. This is a gloomy message because it seems to make the possibility of a hermeneutic of caring seem Utopian. Strict

[1] This was originally part of a lecture entitled The Framework and part of a series of 4 lectures delivered in Bremen in 1949, the other lectures being entitled: The Thing, The Danger, and The Turning.

empiricism abounds, from measuring blood pressure to treating cancer with complex and expensive machines and algorithms. It is hard to imagine healthcare that is not dominated by the complex, technological, fiscal, bureaucratic, and political structures that have become all too familiar.

Ironically, however, technology's potential undoing is *within* the essence of technology. Whilst it cannot be erased, neither can it escape its essence: technology can *itself be rendered as merely* a form of enframing—one among many. An alternative enframing might consist of being open to questions, entering dialogue, being-with, being prepared to self-reveal, co-creating, and understanding. This hermeneutic model of clinical practice makes philosophy, itself, a technology: an alternative to instrumental mechanisation. *Doing philosophy*, being open to patients in a practice of questioning and being questioned, cognizant of the mutually imbricated traditions and subjectivities at play, makes caring intersubjectivity itself, a therapeutic intervention. This hermeneutic of caring describes the preconditions, practices, and outcomes of authentic engagement with patients. Its technology is philosophy as *therapeia.* It is a technology of achieving the ideals of a hermeneutic of care. Philosophy as a practice of alternative enframing redescribes patient and physician in mutually accepted ways that articulate caring. Re-thinking technology as not merely a set of tools to manipulate symptoms towards a 'cure', but rather a contingent rendering of being human, which promises liberation from over-reliance on and naïve use of technology.

18.8 Implications for Health Professions Education

Caring dialogue contrasts informatively with traditional models of the clinical consultation. It is widely assumed that good communication is useful in so far as it hones the information needed to implement biomedical formulae that will manage 'the problem'. This way of thinking about communication presupposes an objective reality, which exists independently of the participants. While biopsychosocial models of care accommodate context, they don't go so far as to frame dialogue as mutually transformative, nor do they adequately recognise the intersubjective elements of interpretation. To the contrary, such models subject patients to interrogations, which objectify both patient and physician as supplicants to scientific dominance. This biomedical, algorithmic management of 'care' reduces the subjectivities of patients and clinicians to the level of fungible parts of a system – standing reserve for the biomedical, 'technologized' mill. Adopting philosophy as a technology of care would subvert the instrumentalization of patient and physician and offer new ways to enframe consultations: communication *as.*

Hermeneutic engagement requires physicians to bring themselves to consultations as human beings with a 'will to share' (Heath 2019), not as people with 'detached concern'. This requires physicians to allow conversations to impinge inwardly, reflecting on their understandings while being open to new understandings that may result from reflection. Physicians can then view patients in the fullness of their humanity, minimizing fear, locating hope, explaining, witnessing, and

accompanying patients (Heath 2019). In this way, physicians can respond to "the unconditional imperative to acknowledge every person as a person…. this seems little, but it is much" (Tillich 1969, 28). Little acts constitute caring. In one of our studies, (Gillespie et al. 2018) we asked patients to describe their experiences of caring. Many times, they characterised caring as paying attention to 'little things', such as phoning to check they were OK, and remembering personal details. These 'little things' were possible because physicians were humble enough to be prepared to share themselves (for more on being humble and humility, see Chapter 24).

Unpredictability is an inevitable feature of hermeneutic consultations, which practice philosophy as a technology of caring. The task is not to provide care as (instrumental) 'solving'. Caring that results from understanding carries risk because it is uncertain, can take many possible directions, and is the antithesis of finding *the* single best answer. It is, as Gadamer suggests, an adventure (Gadamer 1981). The 'art' of clinical care, as proposed by Peabody, is an excellence construed *between* the patient and the physician—the "secret of the care of the patient is *in caring* for the patient" (Peabody 1984, 813, emphasis our own). But adventures don't just carry risk, they offer opportunities as well. Caring as hermeneutic understanding provides opportunities for physicians to broaden their own experience and self-knowledge. We suggest, based on our own experience, that being willing to "hold oneself open in the conversation" (Gadamer 1981, 189) offers an emancipatory opportunity for physicians, which could provide an antidote to the burn-out that results from passive neutrality. Being oneself and revealing oneself to one's patient allows one to engage more genuinely as a carer. It enriches one's sense of being a physician and nurtures one's subjective and existential sense of concern for others. Philosophy as therapeia reminds us of, transformative possibilities for caring.

Caring focuses on the meaning of meeting here and now. This may sound counter-intuitive. Surely a consultation should provide a care plan, next steps, prognosis. Attending to *this* person, in *this* moment, according to *their* concerns, *their* flourishing, however, shows care about who they are, why they are here, and how they are feeling in the present tense. We recognise how this is informed by the past and how this will inform their (and our) future. Illness, care and healing are subjective experiences, too often minimized by placing undue emphasis on tomorrow making longevity the unquestioned goal of care. Perhaps, as Gadamer suggests, the relentless nature of scientific progress, which does not pause sufficiently to allow humanity to keep up, causes many of contemporary society's maladies. A caring relationship can afford a hiatus, when patient and physician take stock of the situation.

18.9 Caveats on a Hermeneutics of Care

Our interpretation of care resulted from conversations between us as authors: two physicians and a philosopher interested in caring. Our presentation is partial; a temporary exploration of a topic, to which many other voices could be added. Interested readers could draw on the writings of Levinas, Gilligan, and Zahavi, to mention a

few (Levinas 1969; Gilligan 1982; Zahavi 2014). We also acknowledge that Gadamerian ideas have been criticised for being overly romantic and failing to acknowledge the power imbalance inherent in clinical relationships. For Gadamer, dialogue and discussion between physician and patient could humanize this imbalance. For a number of subsequent philosophers, however, Gadamer's belief in the universality of hermeneutics and his focus on contextual interpretation and understanding of others on their own terms border on relativism and are insufficient. Habermas, in a series of famous debates, argued that philosophical hermeneutics was a systematically inadequate basis for critical social theory as it fails to pay attention to socio-political and economic injustice related, for example, to race, class, culture, and gender. Since hermeneutics is a 'view from somewhere', perhaps blinkered to asymmetrical distribution of agency and resources, we ask researchers to be alert to limitations that come along with its strengths as a window into society.

Readers wishing to explore these ideas in greater detail may find publications from the growing field of 'critical hermeneutics' informative (Simpson 2021; Kinsella 2006). This umbrella term combines the orientation of hermeneutics towards disclosing general grounds for understanding and interpretation with a sensitivity towards important social, economic, and political factors. We ask readers to be aware that our privileged access to knowledge and other forms of capital may have made us insensitive to important social issues. The 'Black Lives Matter' movement, increasing recognition of systemic racism, and the many excess deaths due to unequal distribution of resources during COVID-19 make it important at the time of writing to scrutinise how societal power manifests itself in the promulgation and policing of health resources. It also demands a re-attention to medical curricula, their colonial legacies, and how education plays a role in privileging some voices, whilst stifling others. For more on social justice within health professions education, see Chapter 8. These concerns encourage us to be *more* philosophical, more attentive to the way technology *renders,* and more attuned to hermeneutics in how we understand patients and ourselves. In sum, to be *more caring*.

18.10 Conclusion

Philosophy becomes therapy when it renders language as care, broadening the concept of technology beyond the purely instrumental treatment of disease. Heidegger conceptualised technology as a way of being that pre-exists us and enframes the world in contingent ways. Within the Gadamerian and Heideggerian hermeneutics informing our discussion, physicians act as philosophers when they enframe encounters with patients through dialogue, openness to questions, "being with" as well as "doing to" patients, revealing themselves, co-creating and understanding. This degree of openness creates possibilities for mutual transformation of physician and patient. Philosophy as therapeia also problematises medical practice that is solely instrumental and invites physicians' doing and being within a more rounded practice of caring (Table 18.1).

Table 18.1 Practice Points

1	Care is a form of human understanding, which promotes healing and well-being
2	Technology is a prime suspect for the loss of care in contemporary clinical practice
3	The central place given to human experience by Gadamer and Heidegger provides a constructive means to reframe the relationship between care and technology
4	This reframing adds human subjectivity and reflexivity to purely instrumental ways of defining technology
5	Extending the concept of technology as we suggest could make *therapeia* the ally of therapy, philosophical practice the ally of clinical practice, and clinicians as well as patients the beneficiaries of a humane as well as 'effective' practice of caring

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Chapter 19
Is Social Media Changing How We Become Healthcare Professionals? Reflections from SoMe Practitioners

Nabilah Yunus Mayat, Sarah Louise Edwards, and Jonathan Guckian

19.1 Introduction

Social media (SoMe) is everywhere, with an estimated 3.96 billion people using SoMe worldwide at the time of writing (Statista 2021). With a use this pervasive, it is hardly surprising that SoMe has been used professionally within healthcare practice. Most frequently, this use takes the form of the development, creation, and dissemination of a seemingly limitless pool of educational resources.

In more recent years however, there has been a significant increase in the use of SoMe for socialising amongst healthcare professionals (HCP) in the form of sharing and discussing ideas, thoughts, and experiences (particularly during the recent COVID-19 pandemic—see Finn et al. 2020 and Brown et al. 2020). However, despite this newfound prominence, and the evolution of the use of SoMe, there has been little deep exploration of SoMe. Though we know SoMe is an all-pervasive source of knowledge, and we could explore questions such as the reliability of knowledge, a focus on knowledge would miss the *social* aspect of SoMe. Is SoMe merely an expansion of educational resources, or is its use changing social relationships within the health professions and health professions education? If SoMe is more than just a place to go to learn an expert's top tips on the management of, say, cholecystitis, then just what is it? And could it be changing our thoughts and practice regarding what professional identity and professional community mean within health professions education? In this chapter, we explore these thoughts in greater depth, offering our

N. Y. Mayat (✉)
Airedale NHS Foundation Trust, Bradford, UK
e-mail: n.mayat@nhs.net

S. L. Edwards
University Hospitals of Leicester, Leicester, UK

J. Guckian
Leeds Teaching Hospitals Trust, Leeds, UK

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perspective as practitioners, educators, and researchers invested in SoMe as to what its changing use means for learners and teachers in our field.

19.2 What Is SoMe?

SoMe is a medium in a constant state of flux. As a result, it is extremely difficult to define (Pettman 2015). Those familiar with SoMe will have their own ideas of what qualifies. Here, we offer our own thoughts as SoMe practitioners, and demonstrate how these align with educational literature on the matter from adjacent occupational fields.

SoMe platforms are driven by evolutionary pressures which include: social trends; corporation profits; and political discourse (Hinton and Hjorth 2019). The overall mission of SoMe is to incentivise users to remain within a community, using the platforms, for as long as possible (Hinton and Hjorth 2019). Accordingly, technology must consistently adapt to these external forces. As trends, profits and political discourse are not static beasts, SoMe is constantly in motion. If you think forward to what SoMe might look like, or constitute, in the year 2025, it is likely your imagination has taken you somewhere very far from what SoMe looked like when it burst onto the scene of popular culture in 2005 (the authors encourage readers of a certain age to take a moment to mourn the loss of Myspace, SoMe giant between 2005–2008).

There is reason to believe that the dynamic and exponential growth of SoMe affects healthcare professionals and their practice, though we do not know in which way. Many current medical students, for example, are of an age where many of them will have never known a world without SoMe (and will likely shrug their shoulders, adopt a look of confusion, or at least raise their eyebrows, at our mention of Myspace, an older platform).

So that we can explore SoMe as a phenomenon more comprehensively, we first must settle on a definition. Whilst we have demonstrated that SoMe is dynamic and fluid, what we are yet to pay due heed to is the term 'social'. This term is so critical to SoMe that it finds its home in the term itself. The use of 'social' within the term social media highlights the primacy of multi-directional user interaction with the medium in question. Therefore, in the context of health professions education, we define SoMe as:

> "web-based technologies which facilitate multi-user interaction that goes beyond fact sharing, for the purpose of content creation, curation or community." (Guckian et al. 2021, 1227)

Inherent to this definition is the idea that SoMe is not only an educational resource in the limited sense of existing for users to share facts and informational titbits with one another. Instead, SoMe can be utilised for the purpose of forming, or engaging in, a professional community. As SoMe practitioners, and so participants of SoMe ourselves, we have both experienced and seen how healthcare learners become part of

a wider social collective. Though some students may 'lurk' on SoMe as passive users, any engagement in SoMe platforms, be it through viewing content or participating more actively in discussions with other users, introduces students to a new multi-professional healthcare community. Particularly for those engaging in discussion across SoMe platforms, users take on rapidly fluctuating digital identities which may develop before they even enter medical school and are introduced to what it means to be and become a healthcare professional—we have seen how some prospective students use SoMe to connect with those established in the healthcare professions, seeking out role models suited to their preferences. Increasingly, we note that healthcare learners possess advanced skills in wielding SoMe to support their education. Further, some learners and trainees use SoMe to critique healthcare and healthcare education in ways that were previously not possible, in part, due to the existence of organisational and institutional hierarchies. What we encounter now as healthcare educators, is a generation comfortable interacting with SoMe, and engaging in its varied uses.

By way of this comfort and engagement, healthcare students and trainees (indeed, even prospective ones as we have previously demonstrated) are introduced and interact with healthcare professionals differently than how they might outside the world of SoMe. We suggest that this has ramifications on the process by which they become healthcare professionals themselves—it influences the way in which they form their professional identities.

19.3 What Is Professional Identity Formation?

Though professional identity can be variously defined, a common definition in health professions education is that it is 'who we are and who we are seen to be' in relation to one's occupational role (Monrouxe 2010, 41). The topic is of increasing interest in health professions education, as educators and researchers recognise the impact of professional identity development on practitioner confidence and well-being (Freedman and Stoddard Holmes 2003; Sabanciogullari and Dogan 2015). For a thorough discussion of professional identity that offers a different view than outlined in this chapter, see Chapter 3 (readers may wish to consider how the concept of subjectification may apply to, or expand, the discussions outlined herein).

However, even if one accepts this common definition, professional identity can be conceptualised from a variety of perspectives. These perspectives exist on a spectrum. On one side of the spectrum, identity formation is conceptualised as a purely cognitive pursuit—identity exists in, and is shaped by, solely the human mind. For cognitivists, identity as a doctor or nurse or physiotherapist is the professional self-concept of an individual grounded in their attributes, beliefs, motives, values, and experiences (Jawed et al. 2019; Ibarra 1999). Social constructionists exist at the other end of the identity conceptualisation spectrum (Rees et al. 2020; See Chapters 10 and 11 for more on constructionism). In contrast to cognitive conceptualizations, they maintain that identity is formed only when learners interact with, and relate to, the world

around them (Goldie 2012). Professional identity cannot be formed in a vacuum by any one person individually—instead, it is interactional, existing only within social relationships.

Given that the formation of professional identity can be variously conceptualised, it is important that we clearly consider how we have defined and conceptualised professional identity within this chapter. We embrace a social constructionist view of PIF, where we position identity formation as occurring only within interactions. As healthcare learners connect with the social world that surrounds them, they develop their sense of who they are in different contexts, and this influences how they act and practice as students and, later, as qualified professionals. Sfard and Prusak (2016) theorise iterative cycles of change to be inherent to the process of PIF—within health professions education this would mean that PIF is constantly renegotiated as a result of dynamic interactions between learners and those that exist in the social world of medicine, healthcare practice, and health professions education. This dynamic cycle of continuous development aligns with our social constructionist conceptualization of professional identity and has informed the analysis and discussion within this chapter.

In the case of healthcare learners, the dynamic cycle of their identity development can occur through the dialogue of narratives (Sfard and Prusak 2016). Individuals are immersed in a variety of social narratives—or stories—on entry to the field of medicine. The stories they hear, see, and engage in ultimately influence their own sense of how they fit into a professional community, and how they should act as someone assuming the role of a particular healthcare professional. In this way, the cycles of iterative interactions learners in healthcare environments experience that influence the way in which their professional identities form are also shaped by the social narratives of a community that inform the way in which individuals interact.

19.4 Where SoMe and PIF Meet

As SoMe is everywhere, those using SoMe are everywhere, too. SoMe has radically changed the social landscape of our world, enabling connections between individuals and communities like at no previous point in human history. As we become increasingly connected, the way in which we are interacting with one another is changing. We have demonstrated how identity can be conceptualised as a social endeavour, formed and shaped in the social space of interactions. SoMe has changed the social space of many of our interactions—how we engage with one another online is different from how we engage and connect in purely physical spaces. We hypothesise that this means the process of identity formation (a social process) for health professionals (who are increasingly comfortable with SoMe) is influenced in some way when learners engage with SoMe.

As we have previously discussed, in our experience, healthcare professionals are increasingly using SoMe to interact with online communities, rather than simply

as an educational resource. What we have not yet considered is how healthcare professionals use SoMe to interact with one another.

Individuals may have separate professional SoMe accounts associated with their professional title and role in their place of work e.g., Doctor, Nurse, Health Psychologist, etc. For some, their professional identity is less clearly divided – there are profiles which are considered personal yet are also used to engage in professional communities. Some healthcare professionals have amassed so many followers and such notoriety that they have become healthcare 'celebrities' within, or across, particular SoMe communities or demographics. Within medicine and medical education, for example, we have witnessed the rise of 'Medical Influencers', or 'Medfluencers', often popular for their expertise, views, and due to the resources they create (Khamis, Ang, and Welling 2016). It is interesting to note that 'Medfluencers' are usually not popular because of (or, at least, not entirely because of), their formal credentials—they develop credibility instead through their popularity (number of followers, and so on). This professional community is different from the physical world for several reasons. Physically, we are unable to completely separate our professional and personal selves—we are whole three-dimensional beings, and usually avoid such strict categorisations of ourselves as either personal or professional. Further, though there may be role models we aspire to in our respective fields, SoMe often offers greater insight into the thoughts, views, opinions, experiences and, ultimately, lives of the 'Medfluencers' we follow and admire.

The complex web of interactions we see between and beyond healthcare professionals on SoMe raises new questions. We do not believe that health professions education has taken enough time to consider what it means to be on SoMe as a healthcare learner, and how this influences the type the healthcare professional learners become – in other words, how they form their professional identities. What impact does separating professional and personal accounts have, and what are the social narratives influencing whether someone chooses to do this, or not? If accounts are blended for personal and professional use, what social narratives shape how people use those accounts, and are there any aspects of the personal self that learners perceive they cannot bring to their professional SoMe presence? How does the presence of, and our relatively unfettered access to, 'Medfluencers' influence how we see our role models, and how we work towards becoming more like them?

In the previous chapter (Chapter 16), Chin-Yee talks of how technology should be understood not as value-neutral, material artifacts, but as a way of thinking and interacting with the world that reflects a range of social choices, and human values. In this chapter, we explore the various technologies of health professions education in this way, by exploring SoMe as a technology influencing healthcare learners. SoMe is not a value-neutral artefact—it is not as simple as saying that SoMe is Facebook, or Twitter, or Myspace (sob!). Instead, SoMe is a new way for learners to think and interact with the world of health professions education and healthcare in a more general sense. In the remaining sections of this chapter, we explore an example of a clearly demarcated SoMe professional community to consider how this community may shape the way in which learners think and interact, and so the way in which their professional identities come to be formed.

19.5 #MedTwitter: A New, Virtual Community Of Practice?

To do so, we offer the example of #MedTwitter, a professional community formed organically on the SoMe platform Twitter. We suggest that #MedTwitter represents a virtual Community of Practice, a conceptualisation that then has significant bearing on how we envision the impact of engagement with this community on learners' emergent professional identities.

19.5.1 What Are Communities of Practice?

To demonstrate that SoMe communities can be Communities of Practice (CoP), and so associated with the documented impact that involvement in CoPs has on identity, it is first necessary to explore what constitutes a CoP.

The term 'Community of Practice' was first coined in 1991 by Jean Lave and Etienne Wenger (Lave and Wenger 1991; Wenger 1998). CoPs are best defined as a process of social learning that occurs when people who have a common interest collaborate and interact in a group (Hopes 2014; Wenger 1998). Though conceived as a theory of learning, involvement in a CoP influences participants' identities as participants engage in a process of 'legitimate peripheral participation' that moves them from the status of 'newcomer' at the edge (or periphery) of the community, to the status of 'oldtimer', engaged in, and central to, the community. As participants engage in the practice of a community, they become increasingly integrated within it, internalising and displaying behaviours learnt within a CoP through a process of 'enculturation' which grants them status of a member, and moves them towards 'oldtimer' status.

Though CoP theory is popular within medical education, it is often misused, or applied superficially. McGrath et al. (2020), in their critical review of the use of the term within medical education, call for clarity when discussing what constitutes a CoP. Initially, Wenger (1998) developed the concept of CoP to propose three definitional criteria communities must meet: mutual engagement; joint enterprise; and shared repertoire. Mutual engagement is the basis for relationship forming—through regular interaction, community members negotiate the meaning of practice within their community. Through the sharing of practice in mutual engagement, individuals create identities which function within the community. Joint enterprise maintains the existence of CoPs—it is not only shared goals, but mutual accountability for the negotiated enterprise that takes place within communities. Finally, shared repertoires include community routine, language, ways of working, and stories within a community. Shared repertoires are generated through shared practice and meaning making – something which suggests longevity, as repertoires tend to develop over time. Later, Wenger et al. (2002) reframed these criteria to increase the applicability of CoP theory as a management tool, naming them domain, community, and practice.

Drawing on the above, we take that there are three criteria communities must meet to warrant classification as a CoP:

- There must be mutual engagement or a common *domain* e.g., a group of paediatric surgeons; MySpace fans; or pharmacists;
- There must be joint enterprise—in other words, a *community* must be established through interaction between those within a common domain; and
- There must be the ability to *practice*. This involves the sharing of resources, continued discussions about topics, and having a repertoire of methods to solve these problems—developing shared repertoires through time (Hopes 2014; Lave and Wenger 1991; Wenger 1998; Wenger et al. 2002).

Utilising the above criteria, the medical community can be seen as a CoP wherein information is shared, exchanged, and debated. This pathway of information between individuals enables the practice of learning, thus fostering the adaptation and development of the professional identity linked to that common domain (e.g., linked to the common domain of becoming or being a doctor, or nurse).

The increasing presence of HCPs on SoMe has led to the formation of communities online (such as #MedTwitter) where HCPs interact with one another.

To determine whether the communities that exist solely on SoMe qualify as Communities of Practice, we analyse the inception and dissemination of a podcast entitled "Two Medics, One Mic" (Lasker and Gunawardena 2021). This podcast has attracted significant attention as a creation, centrepiece, and aggregator of the growing #MedTwitter community. Given this, we hope that analysing this podcast through the lens of Communities of Practice theory may cast light on whether #MedTwitter in its entirety represents a virtual community of practice. As previously, knowing whether CoP theory applies to SoMe communities is important in discerning their possible impact on the PIF of healthcare learners.

19.5.2 #MedTwitter and Two Medics, One Mic: A Case Study

The community of #MedTwitter consists of HCPs, students, and educators, all of whom share a common interest in the world of healthcare, and are present on SoMe, more specifically, on Twitter.

The podcast "Two Medics, One Mic" invites #MedTwitter community members to speak about issues arising from contemporary (and often contentious) #MedTwitter discourse, of which all speakers are a part. The fact that this podcast consists of content generated through discussion of key topics arising as a result of interactions between HCPs on the self-named #MedTwitter shows it to be a topic which would classify as a common domain in itself.

This interaction between common members who are known to one another both on Twitter, as well as on the podcast directly or indirectly, demonstrates that a sense of community is often present within #MedTwitter, and between members. Members often have shared jokes which spread throughout the community. Further, the fact

that this group have named their own community '#MedTwitter' demonstrates a sense of unity and belonging under this label.

As such, discussion of topics seen on the podcast can be classified as a form of practice that have arisen through #MedTwitter. Indeed, 'Two Medics' (Lasker and Gunawardena 2021) is noteworthy for this very reason, as it transcends its recorded setting and spills over into #MedTwitter discussion. The community appears to have rallied around this podcast, inspired to create independent and interactive 'Twitter Spaces' which feature its hosts and guests to continue debate. Subsequently the community has begun to build and critique its own identity, often through debate and challenge. This has not been without trauma, as those with values and ideals peripheral to that of the constantly evolving collective sense of identity with its implicitly agreed social rules can feel judged by others and, at times, upon voicing dissenting opinions, be banished—sometimes literally—to SoMe wastelands. Conversely, a shared identity, centred around recognisable figures and examples of creation, provides a clear roadmap for new peripheral participants to this CoP as they navigate their own online identity (Lave and Wenger 1991; Wenger 1998).

19.5.3 Is #MedTwitter a Community of Practice?: Discussion

The case study illustrates how:

1. Members of #MedTwitter share a common *domain* (they are a group of healthcare students, educators and professionals—most often from the field of medicine and medical education—engaged in SoMe use and interested in sharing opinions and experiences);
2. #MedTwitter is a *community*, in that its members interact, are often known to one another, and there is a shared repertoire of jokes and language;
3. Discussions on SoMe can constitute the *practice* of a CoP. Such networking results in the formation of relationships. Though we have offered up Two Medics, One Mic as an example of this, there are many other ways these relationships can form. Indeed, the book chapter itself is another example of the practice of #MedTwitter at work—we (the authors) all met and formed relationships through #MedTwitter and were approached by the editors who knew of us from #MedTwitter.

Given that #MedTwitter meets the three criteria we earlier set out as constituting a CoP, #MedTwitter as a virtual community can be classified as a CoP with far-reaching boundaries unlike those we may be accustomed to in our physical practice. Indeed, in our experience, #MedTwitter has international reach, with participants from across the globe. In analysing #MedTwitter against CoP definitional criteria and showing that the community meets these, we have shown how it is possible for SoMe communities to constitute a CoP—though we cannot say for certain without further analysis that is beyond the scope of this chapter, it is possible (and likely) that other SoMe communities may also function as CoPs.

The fact that #MedTwitter warrants classification as a CoP has impact in reference to the professional identities of its members. Whilst, according to current literature, SoMe can be considered as a facilitator of the formal curriculum through the propagation of webinars and other resources, if SoMe communities are also communities of practice, fact exchange may not be the only form of education occurring amongst participants of SoMe. Interactions with community members who share a common domain of interest in healthcare operate as a social space in which participants' identities are moulded. As previously discussed, interactions contribute to the dynamic, iterative cycles of identity formation that move between individuals and the social world. It is clear, now, that this social world constitutes not only an individuals' physical experiences within educational and clinical environments, but also their online interactions across SoMe platforms. Though we have demonstrated it is likely that SoMe impacts the professional identities of its members, due to the nature of interactions and because of the relationships that develop within SoMe communities, it is difficult to know exactly what these impacts are without further study. It is crucial that future research explores the nature of these impacts, examining the differences in identity formation between physical and virtual CoPs. It is only through doing so that we will be able to understand how to encourage a generation of healthcare learners who are increasingly comfortable online to form robust professional identities in all the social spaces they move in.

In the following section, we will walk with a learner as they enter and orient themselves to the world of healthcare SoMe. In doing so, we map their trajectory through SoMe as a virtual CoP, highlighting the process of legitimate peripheral participation in action, and speculating as to the possible impacts of the process on the identity formation of learners.

19.5.4 #MedTwitter as a Community of Practice: Mapping a Learner's Journey

As a healthcare learner, your first decision is whether to join SoMe (though you may already be an active participant). The decision regarding which platform(s) to join is one with no fixed answer. Across diverse platforms, a relatively common user journey exists. Individuals sign up and build profiles on their chosen platform, sharing variable personal data, before navigating to online domains of common interest and sharing information in the form of micro-blogs, graphics, videos, or audio files. Most platforms allow users to build on this information distribution through reaction features, such as 'shares' or 'likes'.

A relative divide exists amongst platforms: between public-facing, open communities such as Reddit or Twitter; and those designed to support private conversational networks such as WhatsApp or Facebook Messenger. Whilst SoMe platforms such as blogs or Instagram may consist of an individual showcasing their own views and thoughts etc., platforms such as Twitter and Reddit have an aim of networking

and communication between people. At their core, however, most platforms are algorithm-dominated, designed to construct the illusion of a unique, personalised experience. This personalisation extends to SoMe's 'dark side', including targeted advertising and data harvesting (Hinton and Hjorth 2019). The rapid rise of SoMe, from Myspace in 2005 to complex applications which integrate privacy levels and media sharing such as TikTok in 2017, has shaped our modern population of learners. As previously, learners will likely be familiar, and comfortable, with one or more SoMe platforms before they choose whether to engage in SoMe professionally, e.g., by interacting with the #MedTwitter community.

On their journey so far, our healthcare learner has begun to situate themselves in an online social landscape. They must now decide whether to use SoMe professionally. If they do, they will be prompted to construct an online profile, through which they will interact with others within a virtual landscape of practice. The construction of this profile, being virtual, differs from a learners' physical representation. In the world of SoMe, learners have a chance to construct a profile with far more wide-reaching possibilities than are available to them in the physical world. Indeed, some learners opt for anonymous accounts linked to various healthcare professional identities—a fictional example would be a Twitter account with the handle '@TheMedicWhoBakes, through which its user shares their experiences as a medic with a passion for the culinary arts. Learners may opt for anonymous accounts for many reasons—in our experience, these often involve concerns regarding professionalism and identification, with an increased sense of freedom of speech facilitated by anonymity. How learners choose to represent themselves on SoMe is interesting, as different digital identities can result in a wide range of possible user experiences and interactions. The effects on the user as a result of varying online interactions can differ (Stets and Burke 2005). In the offline world, an individuals' identity performance is usually limited by an inability to control factors such as physical appearance, social context, and non-verbal, subconscious communication. The online world, now, provides an opportunity for learners to create an identity free of usual physical limitations—they are empowered to control the narrative of their identity more than ever before.

Once learners carefully craft their online profile, they will likely explore various online communities they may choose to become members of on the platform they choose, e.g., #MedTwitter. Initially on the outskirts of established SoMe communities, healthcare learners must partake in legitimate peripheral participation. This is made possible as they share a common domain with established members (i.e., being a healthcare practitioner) which grants them legitimacy (Lave and Wenger 1991; Wenger 1998). Permitted to engage in the practice of the community, learners dialogue with other members, becoming familiar with shared social narratives, ways of working, and community repertoire.

19.6 Engaging in SoMe

Given that engagement in CoPs is what allows participants to become familiar with shared repertoires, to truly understand our learners' experiences, we must, ourselves, engage in SoMe. Osberg and Biesta (2008) suggest that knowledge emerges as a result of participation. Only in participating in SoMe will we be able to comprehend learners' experience and appreciate how we may incorporate this new technology into health professions education instruction, to facilitate robust identity development, and perhaps even assessment (for a thorough description and analysis of the shifts in assessment thinking and practice in our field, see Chapter 5; for an alternative view regarding the practice of assessing behaviours and attitudes, see Chapter 6).

We offer an important proviso to our recommendation that educators and researchers should engage with SoMe. That is: they should do so critically. Uncritically throwing oneself into SoMe is as poor practice as dismissing SoMe as a technology with purely negative impacts, or as something you do not wish to engage with at all. But what does a critical approach to SoMe engagement look like? And how can we use this critical approach to explore SoMe in relation to PIF?

We offer up the example of hierarchy to consider a critical approach to engaging in, and exploring the impacts of, SoMe on the being and becoming of healthcare professionals.

19.6.1 Critical Engagement in SoMe: Our Exploration of Hierarchies as an Illustrative Example

One example of how the world of SoMe might be better understood through participation is found in considerations of the nature and practice of hierarchies. Many within medicine and the health professions will be familiar with the concept of a hierarchy—it is akin to a chain of command with higher- and lower-ranking individuals. Most often, hierarchies are based on seniority, role, or status. Power is exercised through hierarchies, with lower-ranking individuals subservient to higher-ranking ones (not exclusively, and lower-ranking individuals do have the agency to exercise power, though this is often more difficult for them to achieve) (Vanstone and Grierson 2021; Brown and Horsburgh 2021).

However, within SoMe communities, we have observed that the hierarchies that exist are different from those we have become used to in the clinical world. On SoMe, everyone is within reach—most individuals can be messaged directly or publically, and senior figures (using our traditional notions of seniority based on role or status) seem to hold less sway based on these characteristics alone. It appears that SoMe hierarchies are flatter than those that exist within the clinical world. Yet, the nuances of this are underexplored—we hypothesise that, though traditional conceptualisations of medical hierarchies may not apply, different conceptualisations might, as 'Medfluencers' can wield significant power. Rather than a hierarchy founded on

credentials, professional qualifications or expertise, our experience on SoMe tells us that hierarchies may be based, instead, on communication, likability, and popularity. Without our experience in this area, we are not convinced that we would have a good sense of this issue, and of the way in which the concept of hierarchy may be different online. It is through our participation in SoMe that this avenue for further research has become clear to us. What is key is that our engagement has been critical – we have taken the time to reflect on the differences between our experiences in the physical world, and online, and question established SoMe practices. In an earlier draft of this chapter, we focused heavily on the notion of flattened hierarchies. However, through supportive reflection and discussions we revised our thinking in this area to our current view (that SoMe hierarchies may be flatter, but they are not completely flattened). We took the time to question our positive regard for SoMe as those who enjoy our time online. Reflexive engagement with SoMe is how we recommend researchers and educators approach SoMe engagement critically.

19.7 Concluding Thoughts

In this chapter, we have considered the ubiquitous nature of SoMe, defining SoMe as a dynamic and fast-moving new technology that goes beyond information sharing to encourage the development of virtual communities of practice. Using a popular podcast as a case study, we demonstrate how Lave and Wenger's communities of practice theory can apply to SoMe communities, reinforcing our suggestion that SoMe is more than a resource, and allowing us to begin to speculate as to some of the impact of these online communities on healthcare learners' professional identities. Throughout, we have commented on the underdeveloped nature of empirical scholarship in regard to the impact of SoMe on learner identities and, in the final section of this chapter, considered why, as educators and researchers who are not immersed in SoMe in the same way as their learners, we may be reluctant to engage, or misdirected when we do engage, with the impact of SoMe on the process of student identity formation.

We feel it is necessary to end this chapter with a call to action for health professions practitioners, educators, and researchers. It may not surprise you that part of this call is for further in-depth, high quality research regarding learners' experiences of SoMe, and the impact of these experiences on the professional they become. This research is complex, since SoMe is an 'unstable' object of research that may have already evolved by the time the research is published. Besides empirical research, we also need to pay attention to the way SoMe may be uprooting our notions of what it means to be a professional, where our community'is', and whether this is changing the nature of education—explorations that would benefit from philosophical and media theory perspectives. To achieve this aim, we must avoid viewing SoMe as something purely negative; we must listen carefully to our learners when they tell us of their experiences; and we must critically and reflexively engage with SoMe

Table 19.1 Practice Points

1	SoMe should be defined and treated as more than an educational resource that facilitates information exchange. Instead, it includes the formation of communities that can have meaningful impacts on the professional identities of their participants
2	Educators and researchers less familiar with SoMe must strive to ensure they don't adopt a potentially narrow view of the impact of SoMe platforms (either negatively or positively). Questioning one's experiences and beliefs in regard to SoMe can facilitate reflexivity
3	Educators and researchers should engage with various SoMe platforms themselves to better appreciate their learners' experiences. Engagement should be critical and involve questioning of established online norms and practices. Group reflexivity discussions may assist in developing a critical approach to engaging with SoMe
4	In tandem to engaging with SoMe oneself, educators and researchers must listen carefully to the experiences of their students, keeping an open mind in the rapidly evolving landscape of SoMe. Hosting discussions that help students reflect on, and so understand, their own experiences and relationship with SoMe might facilitate professional identity formation
5	There are many avenues for future research—we have only scratched the surface in the form of those we have highlighted throughout this chapter. Researchers may wish to consider how healthcare learners' interactions with others differ in the physical world, and on SoMe; how learners' perceptions of their online audience shape the identities they form; and how hierarchies might differ online. We hope researchers will use this chapter as a springboard to consider their own experiences, questions, and open avenues for further research

ourselves, so that we can better understand its impacts, and how these impacts might be leveraged within health professions education (Table 19.1).

We would like to leave you with a quote from the American author Amy Jo Martin that, we feel, captures the essence of much of our discussion:

> It's a dialogue, not a monologue, and some people don't understand that. Social media is more like a telephone than a television.

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Chapter 20
Phronesis in Medical Practice: The Will and the Skill Needed to Do the Right Thing

Margaret Plews-Ogan and Kenneth E. Sharpe

20.1 Introduction

Medicine is in a quandary. Despite remarkable advances in both diagnosis and treatment, there is a growing discontent with healthcare—both from patients, and from clinicians themselves. Indeed, despite advances, medicine has lost its grounding (Inui 2003). In Aristotelian terms one could argue that there has been a focus on the *techne*, or the technical knowledge and expertise of medicine, but a failure to develop the *phronesis* or practical wisdom necessary to *do* medicine in the best way possible. Practitioners need practical wisdom to make tough, everyday decisions in messy situations where guidelines and checklists fall short (Kinghorn 2010). Medicine is about quality of life, not just quantity of life years. It is about the health of human beings who are not objects but choosers. Freedom and preferences are important. It is filled with ambiguity, with difficult choices between competing values, and with the complexity that comes with navigating the human mind, body, and spirit.

We all need practical wisdom, says Aristotle, because we are all choice making beings with the potential to discern both *what* the right thing is to do and—often far more complicated—*how* to do it. The choices we must make often occur in ambiguous, complex, and contradictory circumstances where we rarely have complete information. Rules and incentives are of limited use in getting practitioners to act rightly and can sometimes even undermine their will and skill to do so (Kinghorn 2010; Schwartz and Sharpe 2010). So, what helps us to make wise choices in these complex circumstances? In this chapter, we seek to describe how practical wisdom is necessary for *every* aspect of doctoring. Further, practical wisdom

M. Plews-Ogan (✉)
University of Virginia School of Medicine, Charlottesville, VA, USA
e-mail: mp5k@hscmail.mcc.virginia.edu

K. E. Sharpe
Swarthmore College, Swarthmore, PA, USA
e-mail: ksharpe1@swarthmore.edu

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is the *uber virtue* necessary for the application of all other virtues in the practice of medicine.

We will sketch out some of the everyday decisions doctors make that require practical wisdom and look at why the character virtues and moral skills constitutive of practical wisdom are critical to practicing medicine well. This leads to the question: how can such practical wisdom be learned in medicine? Current institutions which unintentionally undermine practical wisdom can be re-designed to foster it.

20.2 Why Doctors Need Practical Wisdom in Their Everyday Practice

The everyday choices made by medical practitioners involve figuring out what is *relevant*, deciding how to *balance* conflicting goods, and grappling with *how to* do the right thing. Such choices demand practical wisdom (Wallace 1988; Zagzebski 1996). A summary of these problems as they pertain to medical practitioners is given in Table 20.1.

Choices about relevance, balancing, and how-to problems demand practical wisdom because rules, standard procedures, and checklists—our standard decision-making guides—are not enough. That is because:

- These choices are "characterized by multiple correct solutions, each with liabilities as well as assets" and there are "multiple methods for picking a problem solution" (Sternberg 1998, 347).
- These choices are context dependent and there is often no clear rule, procedure, or best practice guideline for that context.
- The choices are not pre-packaged textbook problems but are "unformulated or need reformulation" (Sternberg 1998, 347). So, medical professionals need to figure out the best way to *frame* the diagnosis, treatment options, and likely outcomes.
- The evidence for these choices is incomplete or ambiguous but was the best that could be had at the moment the choice needed to be made.
- The choices are sensitive to patient preferences and the outcome was uncertain, so the patient needs to figure out what risks to incur.
- Even when the medical practitioner knew *what* the right thing was, it was truly difficult to know *how* to do it.

In such circumstances it is *phronesis* that enables medical practitioners to discern the right thing to do and equips them with the skills to do that right thing. What, then, does practical wisdom require? In addition to technical skills and medical knowledge practitioners need certain character virtues and moral skills to make these decisions. We will look at these and then ask: how can health professions education encourage such practical wisdom to be learned?

Table 20.1 Problems requiring practical wisdom

Problem	Description
Relevance problems	Medical practitioners are always making decisions about what is most *relevant* for *a particular* patient in *particular* circumstances at *a particular* time. Which of a patient's major complaints are their chief concern? Is that chief concern really the most urgent? What are the most relevant clinical symptoms for a correct diagnosis—does someone's back pain indicate a malignancy, or bad ergonomic conditions at work? How much does a patient want to hear and how much do they need to hear? Is medical information relevant to this patient at this moment or is tough love, or reassurance? What is most relevant about this patient in creating a treatment plan this patient will follow?
Balancing problems	Often more than one thing is relevant, and sometimes they are in conflict. Sometimes the right medical choices must be balanced with the pressures created by scarce resources, demands for profit, and bureaucratic rules. So medical practitioners are frequently *balancing* conflicting goods Such balancing problems are built into medical practice. Among other examples: how do you balance what the patient wants to choose (patient autonomy) with what the medical professional thinks is best (beneficence—or paternalism)? And what does patient choice mean if she does not want to make the choice, or he does not really understand the situation or is hazy or upset? How do you balance scarce time when the patient load is high? How do you balance the needs of a patient versus the needs of one's own family, or even the need to care for oneself? These tough choices always demand practical wisdom
How-to problems	Knowing what the right thing *is* still leaves tough choices about *how to do it* in the right way. How to deliver bad news to each particular patient—what to say, how much to say, and how to say it? When and how to make an issue of a patient's racism, homophobia, sexism, or religious intolerance directed at a practitioner? How to empower a patient to choose when the very way a doctor frames the diagnosis and treatment options, or presents the statistics and survival rates—even the very tone of voice and body language of the doctor—*always* nudges the patient to choose one way or another? How to respond to a medical error: when and how to report it, how to talk to or help the family or patient, how to set up a system to avoid it in the future—and help doctors deal with mistakes they have made (Plews-Ogan and Beyt 2013)?

20.3 The Crucial Virtues and Moral Skills Practical Wisdom Demands

20.3.1 Virtues

Medical practitioners cannot make these tough decisions without certain virtues which give them the will to do the right thing. Aristotle argues for the importance of such virtues and sees them as learned habits or dispositions (*hexis*). They are "affective" in that they motivate practitioners to do the right thing: to be courageous and

compassionate we need the disposition to act courageously and compassionately. They are also cognitive: we need to know what compassion and courage are—to recognize them, to know why they are important. A short list of virtues essential for good medical practice would also include empathy, honesty, detachment, and fairness. A longer list would include being resilient (having fortitude), being humble, mindful, curious, open to criticism and feedback, self-effacing (disposed to place the patient's interests over the doctor's self-interest), and faithful to the trust a patient puts in a doctor. Also important are the desire to continuously learn and improve, having the willingness to accept responsibility for one's actions, to be open-minded (a disposition to suspend immediate judgment), and having the disposition to collaborate with and learn from others (Pelligrino and Thomasma 1993).

These virtues are deeply embedded in the very nature of medical practice. To say a person lacks compassion, is a coward, is unempathetic, is unreflective, and is not disposed to be detached and to also say that this person is a good doctor, or even a doctor, would seem strange to many both within and outside of the profession. That is because medicine is not just a set of technical skills: it is a practice that aims to serve patients, and that *telos* or purpose includes restoring to health and reducing suffering and harm. These virtues are not optional. They are essential to achieving the aims of the practice. A skilled medical technician might be competent to remove a mole; a good doctor must also be able to have a compassionate, trustworthy conversation with the patient when the pathology reveals melanoma.

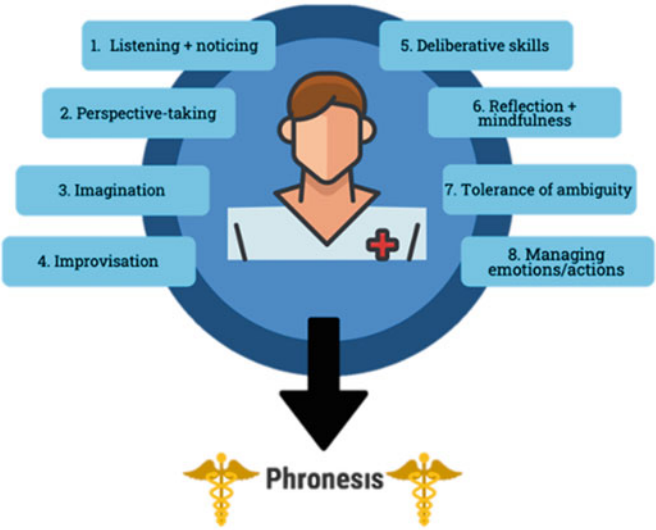
There is legitimate concern that these virtues are vastly under-valued, and even corroded, in medical schools and practice. Later, we will look at examples of two medical schools that have tried to reverse this erosion by restructuring their curriculum and teaching.

20.3.2 Moral Skills

Such dispositions or virtues give practitioners the moral will to practice well, but to exercise these virtues they also need to gain the *capacity* (some might say the *competency*) to actually act: the know how to *be* compassionate, empathic, detached, courageous, mindful, and reflective, and to balance different 'goods' when they inevitably come into conflict. Compassion demands more than the desire to alleviate a patient's suffering; it demands the capacity for empathy (understanding how the patient is thinking and feeling), and the skills to engage that empathy even in situations where the patient is belligerent, angry, or violent toward the doctor; it demands the know-how to figure out what the patient wants and then to balance that with what the patient needs and what the medical possibilities are. Without such moral skills, compassion deteriorates into feel-good incompetence. Similarly, courage demands more than fearlessness or the willingness to act in the face of fear: it demands the technical skills of diagnosis and treatment, knowing how and when to take risk, and the emotional self-regulation to control both anger and fear; otherwise, would-be courage degenerates into foolhardiness.

This capacity to act—to bring these character virtues to bear on medical decisions for *this* particular patient at *this* particular moment to achieve the purposes of medicine—demands what theorists since Aristotle called *practical wisdom.* It is the *will and the capacity to do the right thing in the right way at the right time*. None of the character virtues so essential for being a good doctor can be translated into action without the master virtue of practical wisdom.

A list of some of the closely related skills or capacities necessary for practical wisdom are listed and described in (Fig. 20.1).



1. Listening + noticing	Essential for hearing, seeing and feeling things that a patient herself might not have noticed and to make sure the patient understands the diagnosis and treatment options. These skills demand the ability to suspend judgment to recognize and control social bias.
2. Perspective-taking	The ability to see things from different angles, recognize and question assumptions, and to understand the hearts and minds of patients and caregivers. Such skills are essential for the empathy at the core of good doctoring.
3. Imagination	The ability to see the consequences of a treatment choice and to help those involved imagine this too.
4. Improvisation	The ability to think up alternatives when a procedures does not go as planned, or when a patient does not understand your standard medical explanation.
5. Deliberative skills	The ability to determine the most relevant things at stake in an encounter. The ability to figure out what courses of action are actually possible. The ability to balance clashing aims or values like empathy with detachment, beneficence with patient autonomy, and when to ask with when to tell.
6. Reflection + mindfulness	This includes self-reflection, the capacity to rise above one's own perspective and to see things from many points of view, the capacity for non-judgmental moment-to-moment awareness, and the capacity to notice but not be driven by emotion when making decisions and acting.
7. Tolerance of ambiguity	This makes it less likely that someone will inappropriately simplify a complex problem.
8. Managing emotions/actions	Because interactions between physician and patient aim to be therapeutic, practitioners need self-awareness and self-regulation; the words, gestures, touch, all measured in the same way one measures out pills….right drug, right dose, right time.

Fig. 20.1 Related skills or capacities necessary for practical wisdom

It is important to note that there is a reciprocal relationship here between character virtues and practical wisdom: you can't have good character without practical wisdom, but you also can't have practical wisdom without good character. Practical wisdom is not simply a skill or technique that can be learned. It's not simply learning how to reason, how to analyse, how to do a logical deduction, how to surgically repair a broken appendix, or sew a suture. A doctor can only have practical wisdom if she has developed the virtues that motivate her to do the right thing—and she can only do the right thing if she can exercise good judgment. Aristotle ([350 BCE] 1999) himself emphasized that no one can have the moral virtues without *phronesis* and anyone with *phronesis* has the moral virtues:

> It is plain, then, after what has been said, that it is not possible without practical wisdom to be really good morally, nor without moral excellence to be practically wise. (30)

20.4 What's up with the Tattoo? An Illustrative Case

If medical choice making demands practitioners with practical wisdom—with the character traits and moral skills we have been discussing—how might that look in practice? In our research we have been asking physicians to talk about experiences that they felt would illustrate practical wisdom. Dr. S tells us this story in the Case Study box below.

Case Study Box 1 Dr. S's Story: What's Up With The Tattoo?

JT had been beaten most of his life. He was a patient in a homeless shelter. Mean. Tough. The first day I saw him, he looks at my name. (Dr. S, a typical Jewish last name) …that's your name? He rolls up his sleeve. There is a huge swastika tattoo and it's dripping with blood. I said: "what's up with the tattoo?" He said: "Well…. I think you know." I just by-passed the remark and went on with the medical exam. [Dr. S commented to those of us in the group hearing this story that seven of his grandmother's children were killed in the German camps]. This patient came in many times…….and his sleeve was rolled up….and after many visits, I noticed that his sleeve was not rolled up….and he sent his children to me. Fast forward 11 years later. His last visit. I looked at JT's arm and it was all inflamed where the tattoo had been. I said: "JT: you have dermatitis on your arm, and it looks terrible." I asked him: "what's up?" He bit his lip again. He says: "since I met you, I have been trying to rub it off…."

I don't know if I did anything for his health…. But it was about the most meaningful thing that happened in my professional life. It's calling to us to be in the moment, to be our best selves in terms of the other….

Dr. S told this story to a small seminar (of mostly physicians) exploring practical wisdom in medicine. It did not at first seem as if there were a lot of tough choices here,

but, as our group listened and reflected, we imagined the complexity of the choices Dr. S was making. Before reading our reflections, see what choices you notice, and what virtues and moral skills—the practical wisdom—Dr. S exercised.

Here are some of the things we noticed. Because these traits and moral skills are necessarily interwoven, we will signal the **character traits** in **bold** type and the *fundamental moral skills* using *italics*.

At the start of the exam, Dr. S first had to *notice* that he had a situation of moral conflict, and to *notice* that he had several choices in how to respond. He could have ignored the outthrust swastika and started the exam. He could have challenged JT's anti-Semitism. He could have told JT that he found his tattoo and comment threatening. He could have told JT what feelings this evoked, given what happened to his family in Nazi Germany and used that to critique the patient's anti-Semitism and make a point about justice and bias. He could have said "Oh, that's a well-done tattoo" and gone on with the examination.

His choice was to neither ignore nor confront. Instead, he turned the out-thrust swastika into a question: "what does that mean?" Here, too, he had choices, like his tone of voice. The tone he repeated to us was open, inquisitive, and non-confrontational. He could have said the same words with a very different meaning. And when the patient responded "you know what it means…. your name is S (a Jewish name), isn't it," Dr. S had to make another choice: to engage or to ignore. He chose to simply continue with the exam and work on the health issue the patient had come in with. That patient, of course, had choices too: he could have walked away, or escalated the confrontation, but did not.

Buried in these visible choices are multiple underlying, more subtle choices. For example, Dr. S needed to decide whether the tattoo was a central issue in caring for this patient—was it *relevant* to diagnosis and treatment? To developing a therapeutic relationship? To helping this patient achieve well-being? In solving the *relevance* problem, Dr. S. had to focus on the *purpose* of his activity at that moment. He was not a teacher with a group of 10-year-old school kids confronted by a man flaunting his swastika tattoo in a public place. He was a doctor whose aim was to deliver knowledgeable, skilled, compassionate person-centered care.

Dr. S also had to make a quick *judgment* about the kind of threat this was. He had *perceived*—probably intuitively and not consciously—that this patient was being threatening but was not a threat. Such *perception* was rooted in Dr. S's ability to *discern the context*. The patient's body language and tone of voice, and where he was: in a homeless shelter with indigent poor people, with a variety of problems, psychological, social, and medical.

We noticed that, in the few seconds that Dr. S had to react, there was little time for conscious, deliberative reflection. He could not have laid out four options, weighed the pros and cons of each one, and picked the best.[1] Reflection was crucial for Dr. S. after the fact when he had time to think about what he did and what else he could

[1] On naturalistic decision making and intuition see also Gary Klein, *Sources of Power, How People Make Decisions* (Cambridge: MIT Press, 1998); and Daniel Kahneman, *Thinking Fast and Slow.* (New York: Farrar, Straus and Giroux, 2011)

have done, a 'reflective practitioner' in a post-game analysis (Schon 1983). This fast, intuitive way of choice-making raises other issues about how practical wisdom is learned. Intuitions are not inborn. They are learned. Intuitions can be educated. This was Aristotle's insight in the *Nicomachean Ethics* when he emphasized the importance of developing the right habits before practical wisdom is possible. One lesson here for teaching is to help young medical practitioners recognize the myriad of moral choices they are making in even the most ordinary patient encounters. Another is the importance of a medical education that helps students move step by step from being novices to being experts (Dreyfus 2004), not only in terms of technical skill, but in terms of moral skill.

Dr. S did not react immediately with the common emotions of anger or defensiveness. Dr. S. cannot remember exactly his emotions at the time. One possibility is that Dr. S. felt anger and pain about the bias and anti-Semitism. Another possibility is that Dr. S. did not feel anger or hurt because of the way he *perceived* the situation (JT is suffering) and because of his deep **compassion** (I am here to help relieve that suffering). Another possibility is that Dr. S's habit of **wonderment** and **curiosity** and **problem solving** kicked in: what drove JT to get this tattoo and why is he saying this to me now?

Empathy and **compassion** were clearly at the heart of this story (for a thorough discussion of empathy, see Chapter 5). Dr. S. needed some sense of what the patient was thinking and feeling, and that demanded certain moral skills. He had to be a *good listener*: he needed to read the body language, hear the tone of the words, and to listen carefully to what was medically wrong with this patient. He needed to be **open** to hearing what was on the patient's mind (and in the patient's heart) which meant that he had to have the *capacity to suspend judgment* at least for the moment. To be empathic, Dr. S. also needed to be a *good communicator*. He needed to know when and how to use his own body language and verbal language to elicit what the patient had to say. Thus, his opening question: "what's up with the tattoo?" He also needed the *capacity to tolerate ambiguity and* complexity and to live (at least for a while) with uncertainty (can I go ahead with treatment even though I do not quite understand what is happening here?) (See Chapter 4 for further detailed discussion regarding the nature of ambiguity within health professions education).

Developing habits and feelings of **compassion** are an important part of encouraging practitioners to develop practical wisdom but health professions education must also include fostering the motivation to act when compassion is absent. Imagine a doctor who felt baffled, angry, or hurt by the flaunted swastika; or a doc who intensely disliked this patient; or a doc who could not fathom how someone could think or feel the way this patient did. This doctor-without-compassion might still have given good care in this case because of the habit of duty or his commitment to the Hippocratic oath or a larger faith or some other larger purpose[2] (See also Chapter 5 in this

[2] In a wisdom study Plews-Ogan carried out, this learning process was described by both patients and physicians: at times 'a moral context' or a 'professional code' helped physicians to go through the right motions, even when they weren't feeling it. M. Plews-Ogan M, J. Owens, N May, "Wisdom

book for a more sceptical view of acting compassionately and empathically without feeling in these ways).

Dr. S.'s story underlines another character trait that all doctors need in far less threatening circumstances: the willingness to take risks, to fail and try again. Such **resilience** and **courage** are not so much the overcoming of fear but the willingness to act well in the face of it. JT flaunted his swastika tattoo to be provocative, even threatening. But courage, like the virtues of empathy or compassion or patience, demands not simply the willingness to act in the face of a strong feeling like fear but also the moral skill to choose the right action. Courage demanded the capacity to *imagine* the possible scenarios that could have developed with this person in this shelter at that moment—and thus rule out any immediate danger. Dr. S needed the capacity to *assess the relevance* of what he saw: that the patient was, in fact suffering; that the threatening words were not, in fact, an immediate threat in these circumstances. Dr. S.'s fearlessness could have led to recklessness instead of courage had he not had practical wisdom.

In deciding how to treat this patient, Dr. S needed to *balance* good things that were in conflict. There was no simple rule or principle or best practice that told him how to rank order, prioritize or balance. Standing up against bias and injustice is a good thing—something we expect good doctors to do. Being honest with patients is a good thing. Diagnosing and treating them to relieve pain and suffering is a good thing to do. Protecting one's integrity is a good thing to do. Preserving one's health and safety so that you can continue doctoring is a good thing to do. In making the choice about whether and how to respond, Dr. S. was weighing these things and finding the right *balance* for this patient, and for himself, in this context. This *capacity to balance and weigh* frequently underlies the everyday choices doctors make: this capacity is one of the markers of practical wisdom in a doctor.

20.5 Designing for Wisdom

How then can practical wisdom be fostered? Classroom courses can teach *about* practical wisdom just like they can teach *about* ethics. However good character, good purpose, and good judgment—like good technical skill—cannot be learned without experience. But not any experience will do: it must be well-designed. The extensive literature about the informal or hidden curriculum in medical school has demonstrated how bad mentoring and role modelling, and ill-structured experiences in classrooms, wards and clinics have eroded the empathy, compassion, noticing, and good listening of students (Hafferty and Franks 1996; White, Kumanai, Ross and Fantone 2009). Two examples of institutional *re-design* provide provocative

through Adversity: Growing and Learning in the Wake of an Error," *Patient Education and Counseling* 91 (2) (2013): 236–242; and M. Plews-Ogan**,** N. May, J. Owens, M. Ardelt, J. Shapiro, S. Bell, "Wisdom in Medicine: What Helps Physicians after a Medical Error," *Academic Medicine* 92 (2) (2016): 233–241.

illustrations of how to encourage the learning of practical wisdom and virtue, as well as medical knowledge and technical skills.

One example is the reorganisation of the third-year program at the Harvard Medical School-Cambridge Integrated Clerkship (CIC) at the Cambridge Health Alliance (CHA) (Ogur et al. 2007; Hirsh 2014). Led by doctors like Malcolm Cox (then dean of medical education at Harvard Medical School), David Bor, Barbara Ogur, and David Hirsh, a major aim was to reverse the well-documented moral erosion and decline of empathy among medical students during their third year of medical school (Hojat et al. 2014). What students saw modelled by many doctors was exhaustion from being overworked, little time to mentor students, a focus only on the disease process rather than the person experiencing the disease, demeaning language which de-humanized the patients, and encouragement to get the answers right for the wrong reasons—to please or impress the resident or attending, not because it really mattered for their care of the patient. The CHA faculty totally redesigned the third year of medical school so students learned the medical science, the clinical judgment, and the dedication, compassion and wisdom to stem ethical erosion.

At the heart of the program was designing continuous—longitudinal—relationships: between doctor-teachers and students, between students and patients, and amongst students. The 15 students had their own workspace and meeting area with faculty offices nearby. They met every day at 7:30am for morning rounds together. Instead of a training model based on immersion in hospital wards all day, the students spent every morning in four out-patient clinics (internal medicine on Monday, psychiatry on Tuesday and so on) working one-on-one with the same doctor for the whole year. And each student was assigned 75 patients for the year, drawn from these out-patient clinics.

Their doctor-mentors in the clinic guided the students as they first learned to do patient histories, then how to 'work up' the patients prior to examination, and then how to do diagnoses and treatment recommendations themselves with their doctor-mentor checking back in at the end to hear the students explain, in front of their patients, what they found. Making these students responsible for actual patients in this environment taught them to care by caring, taught them the hows and whys of listening and empathy and good communication because these virtues and skills were not theoretically important but actually important for *their* patients.

The organizing principles of the integrated clerkship program at the CHA are replicated in a growing number of LICs – Longitudinal Integrated Clerkships (Worley et al. 2016).

In our second case these principles were expanded to *all four years* of medical school: the *Phronesis Project* at the University of Virginia School of Medicine (UVA). Originally piloted by Dr. Margaret Plews-Ogan and her colleagues, it was designed to foster capacities for wisdom formation from the beginning of medical training. It emphasized character formation, listening, and noticing skills, and reflective and deliberative practices creating three kinds of long term and continuous—"longitudinal"—relationships for their entire medical school experience: a team of students, a mentor-coach relationship with a faculty member, and a relationship with a patient and their family. In most medical schools, students care for a particular patient for a

few days, at most a few weeks. At UVA, students care for their patients for four years, and a lot happens to people in four years. They get sick, they get well, sometimes they die, and the students experience this alongside their patients, with their mentors coaching them throughout it all.

The student's first task is to take a narrative history of their patient: not their illness but who they are, what is important to them—a context in which to develop an *empathetic and compassionate* relationship with this patient. Then they begin accompanying their patients in medical encounters. Experiencing these encounters through their patient's eyes students learn to practice *perspective taking*, another wisdom capacity that is then re-enforced in their seminars. Students also serve as advocates for their patients in an attempt to overcome socioeconomic barriers to health. Discussions in their weekly seminars include the role of physician advocacy in achieving the greater good for society. By the end of their first year, students begin in-depth clinical discussions of their patients with their mentor and each other: what is going well, what is particularly challenging, what has worked, and what is *not* working? Their clinical role expands in the second year as they are assigned tasks such as helping their patients adhere to treatment plans which in turn involves understanding the obstacles to such "adherence" because of health literacy, belief systems, culture, economic and social barriers. In the third and fourth years, students meet monthly with mentors to discuss their patients, their experiences in the clerkships, and their moral and clinical conundrums. They are encouraged to challenge each other, and themselves. They are encouraged to see their failures as critical opportunities to mature as clinicians. Their mentors are encouraged to share their own failures and limitations, and how they balance competing goods and uncertainties.

20.5.1 Wisdom-Generating Design Elements

These cases indicate some of the important design elements that can generate the learning of practical wisdom.

20.5.1.1 Role Modelling, Coaching, and Mentoring

In the formal curriculum, teachers teach the ideal. Evidence suggests that the *hidden* and *informal curriculum* is where students develop habits and character traits of ethical practice by observing closely what the teachers and head nurses and doctors actually do in practice and trying to align that with what they have learned in the formal curriculum (Hafferty 1998). That process need not be left to chance. Coaching and mentoring, if longitudinal—consistently done over time—can help students to unpack those experiences (Maini, Saravanan, Singh and Fyfe 2020). They can then realistically reflect on what is needed to live out wise action even in tough circumstances (Sharpe and Bolton 2016).

To offer one example, Vanessa's (a student in the CIC programme) doctor-mentor in the internal medicine clinic at CHA, Dr. Pieter Cohen, had her review out loud, in front of each patient, what she diagnosed and what she would prescribe. He not only told her stories from his own experience, but routinely asked her questions to help develop her ethical sensitivity: How do you think the patient felt when you gave the diagnosis? How did you feel? What kind of response did they make (in words or body language)? How much truth should you tell this patient and when? Why did you nudge the patient this way (toward drugs and not diet; toward wait and see instead of surgery)?

20.5.1.2 Reflective Practice

The kinds of questions that Dr. Cohen asked Vanessa are at the heart of an experiential learning cycle designed to teach reflective practice, Experience/Practicing→ Reflection → Deliberation and Learning → Experience/Practicing Again. This is illustrated in Fig. 20.2.

Note that this is not a linear path but a circle—a kind of virtuous upward spiral, and the starting place of this learning cycle depends on the subject matter, the practice and people's learning styles. The "practice" generates the urgency, and the 'realness' of the learning. Reflection demands nurturing the capacities for learning how to notice.

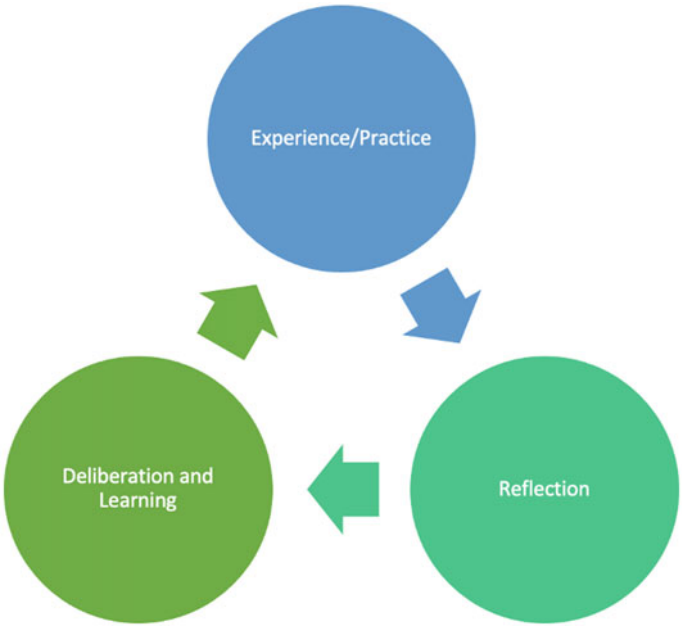


Fig. 20.2 Experiential learning cycle

Deliberation demands figuring out what worked and didn't and why—and what to try next. Students learn ethical judgment the same way they learn technical judgment: in an environment which allows for trial and error without putting the patients at risk. The CHA and Phronesis project set up environments in which the practice generated the urgency—the realness of the learning and the need for reflection and deliberation. They were also environments of trust and curiosity, rather than judgment or shaming. As one CHA student put it:

> There are so many ways to get it wrong when it comes to counselling a patient, to figuring out how to get them to accept treatment, to allaying their fears, to giving them hope, to helping them make good choices – knowing when to choose for them, knowing when to let them choose, and helping them make those choices. These are the kinds of daily ethical questions so important for good doctoring.

John, a pseudonym for a student in the Phronesis Project, remembers how stunned he was when one of his patients used a racial slur—how conflicted he felt between his duty to treat the patient with compassion and the duty to treat all people with respect. He said nothing. Neither did the nurse who witnessed the encounter. But he was able to talk with his coach, unpack his assumptions, and think through possible responses– to such a patient and to the nurse.

20.5.1.3 A Focus on Teamwork and Intra-Professionalism

The practical wisdom of modern medical practice is no longer a solo act: increasingly, wise decisions about the treatment of chronic illnesses or complex psycho-social problems depend on teams learning the skills to work together to see the different aspects of the context and the different interrelated problems of the patient and come up with wise suggestions, delivered wisely, for this particular patient. Both the CHA and the Phronesis Project intentionally designed learning environments to encourage medical students to work in teams, to listen and communicate, to dialogue and brainstorm.

The students in the CHA clerkship team each take turns presenting a case from one of 'their' clinic patients during morning rounds with their doctor-coach. The doctor-coach has modelled the steps of a differential diagnosis but over the weeks increasingly sits back to let a student present and the team work it out—coming in at points to push and nudge: "I want you to be more like lawyers here…. push back….what's missing…what's the story of the case….can you tell another story?" Each student has two morning sessions to present their case—and can't reveal the actual diagnosis the first day. The first session leaves the team—the class—puzzled. Their mission is to figure out the diagnosis and the treatment for the next day—and test their ideas against what actually happened. The students learn the skills of listening, empathy, cooperativeness, and collegiality necessary to work as a team.

20.5.1.4 Continuity of Relationships over Time

Undergirding many of the design elements above is continuity: allowing young practitioners a continuity of experience over time with their mentors, patients, and colleagues. The experience of such continuity over time encourages reflection. It allows practitioners to learn how to understand the thoughts and feelings of patients. Continuity also encourages the experience of trust building and loyalty among practitioners which then allows a safe environment where learning can take place through trial and error, and young practitioners have the opportunity to practice mindfulness and be present.

At the CHA the third-year students work in their four weekly clinics with the same patients and the same doctor all year. And every time one of the 75 patients assigned to a student enters any part of the hospital or clinic system, the student's pager goes off. If at all possible, the student drops everything to accompany that patient. In the Phronesis Program at UVA a medical student has the same faculty member as mentor-coach for all four years and is assigned a patient (and family) to follow from the beginning of the first year. This allows students to see how health and treatment develop, understand a family's joys and fears, learn how to adjust when something does not work, and be able to advise or counsel the patient and other doctors. Jeanne (a student pseudonym) was at the ER at UVA hospital when a patient she had known for 3 years unexpectedly had a serious reaction in an infusion centre and was being rushed to the ER. In 3 min, while waiting for the patient, Jeanne could give a concise history of the patient's medical care to the team (without even looking at the records). After the patient passed away, she stayed another few hours with the patient's family who she had come to know. Jeanne called her faculty mentor: "What do I do? I've never experienced this before…I've never talked to a family." Her mentor, who rushed over to accompany Jeanne as she talked to this family, remembers: "it was stunning to see this student navigate this on behalf of the patient and ultimately the family. I had been mentoring this student-patient relationship for the last two years so she could call me: there was patient care continuity, there was educational continuity. It was how it was supposed to be."

20.5.1.5 Build Uncertainty Training Into Health Professions Education

Medical decision making often takes place in situations of uncertainty, ambiguity, incomplete information, complexity (for more on ambiguity, see Chapter 4). Medical practice during the COVID-19 pandemic was an extreme version of a common set of circumstances: the limits of "standard operating procedures," rules and algorithms. Unlike medical school tests, there are no right and wrong answers. Yet, uncertainty often rubs against the grain of a medical culture which encourages young doctors to show their expertise by being decisive, by being certain. That is why attendings often pretend to be more certain than they really are. So medical education needs to be designed to train students in the character and the practical wisdom needed to deal with decision making in complex and ambiguous circumstances – to encourage

students to practice the courage, patience and honesty, and the practical skills needed to make decisions in the face of such uncertainty.

At the CHA and the UVA Phronesis Project, students are encouraged to learn that when you think you have the answer that it's not the whole answer. Often, that becomes clear only with information gathered over time. At UVA, for example, students are coached to spin out what they expect the results of the treatment plan to be: if this is pneumonia and you treat with this antibiotic, what do you expect will happen? The expectancies create the rules of the game going forward: there is uncertainty until you see what happens—and if your expectations are not met, then what will you do next? The students are encouraged to extend the uncertainties and be prepared to alter their diagnosis and treatment plan. Each diagnosis and treatment is a test situation because, until the patient recovers, there is still uncertainty, and you always need to go through the process of reflective deliberation: what did I get wrong, what do I see or notice now, what do I think it means, how do I test for it, what do I try next? And how do I share this process with patients, to empower them and to sustain their trust?

20.6 Conclusion

Medical knowledge, technical skills and *phronesis* are at the core of good medical practice and health professions education. *Phronesis* rarely gets its due, even as most health care professionals will give a nod to the importance of character and good judgment in health care decisions. Too often, medical schools and health care institutions ignore the importance of educating for practical wisdom; worse, the ways their formal and informal curriculum are designed can erode the very wisdom that good medical practice demands. That corrosive situation can be turned around by designing for wisdom (Table 20.2).

Table 20.2 Practice points

1	Role modelling, coaching, and mentoring can generate the learning of practical wisdom
2	As reflective practice fosters phronesis, teachers must be conscious of how they teach students to be reflective. The experiential learning cycle can be utilised to this end
3	Designing learning environments to encourage medical students to work in teams, to listen and communicate, to dialogue and brainstorm fosters teamwork and inter-professionalism which, in turn, facilitates practical wisdom
4	Relationships that endure over time with mentors, teachers, peers, and patients are critical in providing students with the space to practice the necessary skills or capabilities that make one practically wise. Programmes should be designed to foster such educational continuity
5	Situations which encourage students to consider and be immersed amongst uncertainty should be built-in to medical curricula

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Chapter 21
In Pursuit of Time: An Inquiry into Kairos and Reflection in Medical Practice and Health Professions Education

Sven Peter Charlotte Schaepkens and Camillo Quinto Harro Coccia

21.1 Introduction

In teaching and practicing medicine, there is pressure to work efficiently and be task-focussed (Hodges 2010). Although there are only so many hours available in a day, staff and trainees need to absorb the ever-expanding volume of technical knowledge and manage an increasingly complex medical practice (Cunningham and Sutton 2008). In response, scholars have begun to rethink the meaning of 'taking time' and being a health professional in a demanding environment where time is precious (Kumagai and Naidu 2021; Wear et al. 2015). Indeed, taking time is easier said than done, particularly in reference to reflective practice: "for busy professionals short on time, reflection runs the risk of being applied in bland, mechanical, unthinking ways" (Bindels 2021, 8). Likewise, trainees who are task-oriented find little motivation to voluntarily reflect (de la Croix and Veen 2018; Chaffey et al. 2012; Albanese 2006). Nonetheless, medical educators are encouraged to help trainees take time and integrate reflection into the curriculum (Mann et al. 2007; Albanese 2006).

A lack of time challenges reflection because it is assumed that "taking time to stop, think and evaluate" is a fundamental component of reflection, which could reduce burnout (Lack et al. 2019, 228; Kuper et al. 2019).

> Taking time to work through an experience that breaks in some way with the expected course of things allows students to return to and begin to make sense of that which troubles or delights them. (Wear et al. 2012, 608)

Similarly, medical staff need reflection time to process emotions to cope with work pressure (McPherson et al. 2016). Therefore, at first glance, we ought to designate

S. P. C. Schaepkens (✉)
Erasmus University Medical Centre, Rotterdam, The Netherlands
e-mail: s.schaepkens@erasmusmc.nl

C. Q. H. Coccia
University of Cape Town, Cape Town, South Africa
e-mail: camillo.coccia@uct.ac.za

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specific portions of our schedule to document an appraisal of our day. Although this is valuable, there are alternative ways to think about taking time and reflection.

Contemplation for early Greek thinkers was never seen as a task or activity, but as precisely the opposite, as freedom from tasks and activities in order to think (Arendt 1958; Pieper 1963). In this chapter, we introduce the Greek notions of *kairos*, *chronos,* and *scholê* to explore taking time to think without it being a scheduled task during a busy day. Then, with Walter Benjamin's work on time, we explore why *kairos* is important to question an instrumental view of reflection as a task. Finally, we discuss the practical implications of *kairos* for medical practice and education.

21.2 Experiencing Time

When we boot up our devices during our medical practice or at our medical schools, a calendar app or other time management technology appears on our screens to structure our day. They produce notifications that flag upcoming tasks, that we should move along to our next meeting, or that patients are waiting. What can this experience with time and calendars tell us about taking time and reflection?

Generally, calendars create order in an otherwise demanding environment. Such technology provides a convenient overview of tasks and helps us keep track of our day. Calendars divide tasks into manageable items that are either 'to do' or 'done'. They offer a gratifying sense of closure when something gets done, while they also generate urgency, nudging us along to our next task. Presently, to imagine work without the benefits of such organisational technology is hard. Its integration with our daily tasks epitomizes and shapes the experience of our work as a sequence of events that requires management (Giddens 1987).

Calendars provide a beneficial sense of control; however, they also require micromanaging. Calendars divide time into distinct blocks by singling out individual moments with abstract tokens like May 6th 2021, 08:30–09:15. As such, calendars prompt what some philosophers call the 'vulgar' interpretation of time. Time is an abstraction that exists independently of man and is measured by clocks (Keller 1999). Although measurement with clocks helps us 'be on time', its "increased accuracy leads one to become more and more concerned with ever smaller units of time" (Keller 1999, 196). We divide our worktime with greater precision into neat, chronologically organized blocks. We have one hour to finish task X, then twenty minutes for meeting Y, fifteen minutes' lunch, and afterwards ten minutes per consultation. In sum, pre-allocated time slots dictate the pace of our work as an endless string of loosely connected, sequential moments.

While we are very familiar with how calendars work and adapt to them, something else happens when loved ones ask how our day was. We never list a perfect sequence of chronologically transpired events as if we were calendars ourselves. We are not objects "that correspond to statements about events occurring at various clock-times"

(Keller 1999, 240). For instance, the day was not hectic at 15:37; instead, I experienced a hectic day because I was invested in doing my job and fulfilling my roles. I will tell my loved ones a story about tensions, and that too many things converged around midday, and *how* I was unable to cope with my responsibilities (Keller 1999). These stories punctuate an otherwise abstract flow of clock-time, and illustrate how we are deeply, personally invested in our surroundings.

21.3 *Chronos* and *Kairos*

The two aforementioned ways of time perception, time as a 'chronological sequence of events' and as 'lived experience', can be put into perspective with the help of an Ancient Greek distinction (Sipiora and Baumlin 2002). Greek thought offers the notion of time as *chronos*: a destructive force of time, "an objective, measurable time and a long duration of time" (Lindroos 1998, 11). Time is uniform with each second, minute and hour lasting exactly the same amount since the beginning of time. Such time is about "quantity of duration", and prompts questions like "How fast? How frequent? How old?" (Smith 2002, 47). Time receives order with 'before' and 'after' that provide a "grid upon which processes of nature and the historical order can be plotted" (Smith 2002, 49). Our experience can, thus, be timed and standardized, allowing us to date events, which is vital for how we organize life and our historic understanding. In contrast, Ancient Greeks also know of time as *kairos*. This notion is complex and multidimensional, since it was used variably throughout Greek culture in epic literature and tragedy, and spanning among others Presocratic, Platonic, Aristotelian, Sophistic and Stoic philosophy and rhetoric (Sipiora 2002; Kinneavy 2002).

Generally, *kairos* is related to the meaningful moment, "the uniquely timely, the spontaneous, the radically particular" (Miller 2002, xiii; Lindroos 1998). It is "the right or opportune moment to do something, or right measure in doing something" (Kinneavy 2002, 58). Rhetorically, *kairos* implies that one can learn theories and strategies based on previously successful discourse, but theory cannot "cast a net over the unforeseen, unpredictable, and uncontrollable moments" (Sipiora 2002, 6). Speaker and audience find themselves in a unique context that requires adjustment and reinvention of discourse in the moment itself. As Aristotle argues, *kairos* is situational (Kinneavy 2002; Kinneavy and Eskin 1994). Beyond rhetoric, *kairos* spans many other dimensions of experience. *Kairos* particularly comes into play when we face decisions in unique situations about means and ends, morals and values "that cannot be a matter of law alone but require wisdom and critical judgement" (Smith 2002, 56). To explore *chronos* and *kairos* for medical practice and education, we turn to a personal experience of one author of this chapter, Camillo Coccia.

Case Study:
I was on a night shift in the Emergency Room and saw a new patient brought in. Exhausted, I paged through a file and formulated the problem list: 26-year-old, end-stage cervical cancer, now with loss of appetite. Working in this particular Emergency Room, I had seen a multitude of patients with these conditions and was already thinking of a possible differential diagnosis and a set of investigational strategies for the particular pathology that might be present. Then, I noticed the frontmatter of the file and was struck by recognition. I had met this person before, but looking at her face now, she was unrecognizable. Wasted and delirious, the patient did not resemble the memories I had of her.

We might not be so blithe as to justify Coccia's bleak encounter as a mere learning experience, but also perceive it as something much more profound and upsetting. In Coccia's case, the face of a suffering patient no longer disappeared behind the usual signs, symptoms, and procedures that help 'transform' people into patients. Here, a rupture occurred between *kairos* and reason (*logos*). Reason deals with generalizable ideas and truths that are steady throughout time, whereas *kairos* represents "the special occasion in the course of events when such truth must be brought to bear by an individual somewhere and somewhen" (Smith 2002, 53). For Coccia, the patient ceased to be just another scheduled patient who rationally represented a typical case of cervical cancer. *Kairos* illuminated the contours of Coccia's general ideas of 'being a doctor' and 'cervical cancer' that normally guide him on the job (Dewey 1933; Garrison et al. 2012). Moreover, the ideas partly failed him in *this* confrontational moment. In unique situations, *kairos*-thinking emphasizes the individual and calls for critical judgment "on the value and norm aspects of ideas" (Kinneavy 2002, 63). *Kairos* provides particular constellations of events that create *opportunity* (*opportunitas* as the Latin translation of *kairos*) for a qualitative reappraisal of ideas or transitions (Smith 2002). To make sense of such disruptive experiences, doctors and trainees might need additional time to incorporate such confrontations with death and suffering back into their clinical understanding, and we ask how *kairos* invites further reflection.

The day can be divided in time at work and time off work or leisure time. Ancient Greeks had a particular view of empty leisure time that contrasts with ours. Their notion of leisure time was *scholê*, to which our word 'school' is etymologically related (Skeat 2005). We might assume that *scholê* as leisure means time free from work, or time spent away from specific commitments. In Greek thought, however, work was a time during which *scholê* was impossible (Pieper 1963). The negative *ascholia* describes everyday work activities and labour connected to the basic necessities to sustain human life (Kalimtzis 2017). *Ascholia* contrasts with the more fulfilling times of life in *scholê*, which is a conscious abstention from any such necessary labour (Arendt 1958). Moreover, Aristotle saw *scholê* as an end in itself. It was not leisure on the weekend as time off from work that had some specific goal, like resting

so we can improve our functionality when we go back to work (Zimmern 1911; de Gennaro 2020). Neither was *scholê* a comfortable state of mindless relaxation or consumption (Arendt 1958). On the contrary, lacking specific goals in *scholê* is what is valuable, and does not make time spent in leisure void or pointless. Why is that so?

Taking time without having a goal in mind can reinvigorate previous understanding and knowledge. The common formulation of knowledge and reflection in health professions education is to understand phenomena in terms of their existing purpose: 'I reflect in order to improve myself at task X…' (Kolb 2015; Coffield et al. 2004; Winkel et al. 2017; Roessger 2014; Nguyen et al. 2014). Teaching trainees about these pre-existing purposes that are embedded in standard procedures, basic facts, and learning goals is valuable. For instance, reflection during a pre-scheduled reflection session on Thursday from 10:30–11:00 can prompt goal-oriented reflections that move within the regular parameters of work. A goal-oriented reflection by Coccia could include evaluating how he can more effectively execute protocols for cervical cancer patients or re-assess the adequacy of his doctor-patient communication when doctors know patients privately. Such reflections are important and functional. Moreover, they are likely to occur within accepted parameters because *at work* we are deeply invested in our roles and responsibilities that come with our jobs (Keller 1999). However, Coccia could also focus on the shock and disruption of the encounter; how someone's personhood disappears behind a disease, medical graphs, and symbols, and address the upsetting weight of the encounter in the face of his medical task to deter death. It is in *scholê's* absence of goals that reflections could move beyond accepted reflective parameters that predetermine how we should 'normally' function and reflect during *ascholia.*

In sum, when we contrast *scholê* with our contemporary view of time, we see how we presently divide time into periods of working and periods that are before or after work. The periods that are within worktime are usually goal-oriented, organized by the helpful *chronos* grid. From Greek thought we take that *kairotic* moments could disrupt us from this way of working habitually and move us away from the grid. We are, for a moment, not ensnared by our calendars to achieve our micromanaged string of goals but receive the opportunity to question our ideas. Now, we can ask why disruptions and questioning our ideas are valuable, for which we turn to the philosophy of Walter Benjamin.

21.4 Walter Benjamin

When we commonly think about time spanning years, months, or even weeks, we tend to use the following *chronistic* method of making sense of the present. A patient's history requires a general overview of many particular points of significance that culminate in a timeline that explains the present. This method represents how all these moments are (causally) interconnected and lead up to the present condition. However, sometimes, a small piece of information can entirely reorganise the way we

understand the timeline and radically alter our current understanding and diagnosis. For instance, a doctor might presently notice an error, a missing piece of information or uncover a lie from a patient which disguised a latent problem. For Benjamin, an early twentieth century thinker, this was not exclusive to patient histories but more fundamentally applicable to our historical understanding and personal lives. However, Benjamin also noted a cultural trend that posited a current state of affairs only as an inevitable result of the past – as if a series of events pointed unequivocally to the present and on toward the future. This trend is widespread, and, we argue, also prevalent in medical practice and education.

Born in Berlin in 1892, Benjamin was a member of a wealthy Jewish business family. In 1940, he took his own life after a failed attempt at crossing the French-Spanish border. His writing intertwines different disciplines and covers high and low culture (Rosenthal 2014). His style is fragmentary and associative, which some call kaleidoscopic (Lindroos 1998). Besides classically written academic work, many manuscripts consist of assemblages of shorter texts, aphorisms, quotes, or vignettes. They:

> …provoke his reader to reject the idea of the linearity of the text, and to approach it as separate pieces of thought, which, however, become bound together in the act of reading. (Lindroos 1998, 32; Löwry 2005)

In the following, we explore some of his views on time in reference to his treatise 'On the concept of history' (1940) (Benjamin [1942, 2006b). We further elucidate these with his biographically inspired vignettes from *Berlin Childhood around 1900*, which he started writing in 1932 but was only posthumously published (Szondi 2006; Cosma 2019; Steiner 2010). The breadth and depth of Benjamin's work on history and time is complex and extensive. Here, we only introduce his work for the sake of medical practice, and it is by no means exhaustive.

21.5 A Boy in Berlin—A Man in Paris

It is 1932, and Benjamin tries to come to terms with his pending exile. He starts writing about his earliest memories from when he was a boy in Berlin around 1900, and once in exile in Paris in 1933, continues working on this project (Steiner 2010). His aim is not objectively chronicling some facts about his Berlinian past; rather, his descriptions cause images from past and present to clash (Cosma 2019). For instance, in his vignette about the larder:

> With what endearments the honey, the little heaps of currants, and even the rice gave themselves to my hand! How passionate this meeting of two who had at last escaped the spoon! Grateful and impetuous, like a girl borne away from her father's house, the strawberry marmalade let itself be enjoyed here without a roll and, as it were, under the stars; and even the butter tenderly requited the boldness of a suitor who found entry into its humble quarters. Before long, the hand – that juvenile Don Juan – had made its way into every nook and cranny, behind oozing layers and streaming heaps: virginity renewed without complaint. (Benjamin [1950] 2006a, 128–129)

With these descriptions, Benjamin adds layers of meaning to a moment in the past that encompass more than just grabbing food from a larder. Items become objects of desire, hands turn into lovers, the larder is a place of excitement. Butter and marmalade are no longer mere ingredients but come to life and act like willing lovers who give themselves to an eager hand. No longer is slipping a hand through the crack of the larder door an act of boyish thievery; it is a passionate meeting and erotic exploration. The spoon, perhaps a symbol of restraint, correctness, and proper etiquette, no longer constricts those who want to meet more intimately. Side-lining the cutlery even underlines the physicality of the act of touching food with fingers, or touching another's naked body. Lovers find each other, unencumbered, and the butter even rewards the carnal approach of the beloved. The boy's hand transforms into a bold Don Juan, who unveils and explores the lover's body, encountering oozing layers and streaming heaps in every fold and crevice, nook and cranny.

Benjamin's larder vignette contrasts with the interpretation of the present as the outcome of a string of past events. In short, Benjamin moves from understanding time as an overly *chronistic* clock-time that is mechanical and linear, to a meaningful lived moment filled with *kairotic* potential where past and present are not seen linearly (Lindroos 1998; Kinneavy 2002). This vignette exemplifies this move, and is what Benjamin calls a 'dialectical image'. He understands an image in broad terms that includes photographs or illustrations, but also mental images, memories, or knowledge (Wiegel 2015; Lindroos 1998). Generally, we think of images as static objects. Photographs or films freeze moments in the past, and memories could, likewise, be seen to encapsulate past events that we carry with us into the present. Benjamin, however, argues that images are not always purely static or unchangeable; images can move, too (Lijster 2016). In the case of the larder, an image from the past (the Berlinian boy) clashes with the image of the present (the man in Paris). How is that odd clash visible in the vignette?

Benjamin's vignette mysteriously ends with 'virginity renewed'. This sentence accentuates the collision of images, since we wonder whose virginity has been renewed. It is unlikely that the nine-year-old boy in Berlin has lost his virginity, or that he was overly conscious of any eroticism when slipping his hand in the larder. Therefore, we might assume that it is not the boy whose virginity is renewed but the man's. By revisiting the image of a nine-year-old Berlinian boy from an adult perspective in exile, the youthful act of breaking into the larder in the past collides with an image of eroticism that only the adult Benjamin is conscious of. Something erotic is revealed in the acts of a boy in the past, while something boyish simultaneously shows itself in an adult's idea of eroticism in the present. In the confrontation between past and present, Benjamin changed: his virginity was renewed.

Benjamin names this back-and-forth between past and present *now-time*, which has two qualities. First, truth as we presently know it is no longer the result of a stable progression of history. Conversely, truth for Benjamin is dynamic. Truth (re-) establishes itself "in the right constellation of words and things, as a montage of ideas, or as a (re)construction of previous truths" (Lindroos 1998, 63). For instance, in the larder the 'adult man' and his understanding of his idea of eroticism and virginity clashes with the boy's world of stealing larder goods. In the present, these

two merged and constitute new meaning. Similarly, in Coccia's experience, seeing a woman Coccia knew from the past clashed with the present wherein she appeared as a patient whose personhood he barely recognized. For Benjamin and Coccia, past and present came together and shifted their understanding. In Benjamin's case it shifted his idea about eroticism, and it made Coccia reconstitute his idea of being a doctor deterring death.

The second quality of now-time is that it allows us to advance into the future without being fully determined by our past, while we simultaneously hold some connection with our past. Simplified, in now-time, one is not prompted to say: 'because I am a doctor, I will always perceive every patient I henceforth encounter in the ward *as a patient*.' We simply do not function mechanically, and now-time captivates the dynamic understanding of ourselves "by virtue of the interruptive force [that images] are understood to impart to experience" (Osborne and Charles 2020). Now-time loosens the tight, causal chain of history that one-directionally determines the meaning of the present. In Coccia's case, his past and medical surroundings prompt him to predominately think and 'be' a doctor who treats patients, yet the encounter with the cancer patient he once knew privately made him question this truth.

Benjamin stresses the importance of upsetting any simplistic, chronological interpretation of our (personal) history because we so easily explain our present as the unidirectional result of our past. For Benjamin, the past is never settled, especially when it clashes in *kairotic* moments with the present. These confrontations hold the potential to change our understanding of ourselves and the ideas we inherit from the past.

21.6 Historicism

Benjamin's aim to upset an overly *chronistic* way of thinking about time is embedded in his work on history and time in his *Arcades project* and in a series of theses 'On the concept of history', written in 1940 (Steiner 2010). The war and political situation prompted him to revise the traditional view of history that he labelled *historicism*, which was conducive to the dire political situation (ibid). Historicism implies interpreting history as a linear evolution through time. Where we are today is unequivocally the product of our past, that steams onwards towards an inevitable future. The causal chain of successive historic events determines us. A positive historicist interpretation of history shows how we ultimately move towards utopia, whereas a negative historicist interpretation shows how we end up in a dystopia (Lindroos 1998). History becomes *teleological*; it moves towards its end-goal or final purpose that is foreshadowed in the past. Historic examples include the arrival of true communism or the Third Reich.

Benjamin does not question the truth of historic facts or their chronological order; rather, he criticizes historicism's way of relating to the past as a solely linear process towards a certain future, and how we naively adopt such views elsewhere. Academic

ways of relating to history influence politics, culture, and trickle down to how individuals relate to their own personal time and work. For example, a historicist interpretation of ourselves entails that 'I am the product of (my) history, and as a doctor I simply follow protocols handed down to me'. We do not imply that protocols should always be questioned. However, "the uncritical reception of tradition implies a problem, which is transferred into a 'truth' of this heritage and is conceived of as temporally stable and non-transformable" (Lindroos 1998, 56). The past washes over us like a big wave, and individuals can only undergo its advancement, act along, or even use the past as an excuse to evade responsibility. The simplest version of the latter would be insisting on 'I did not have time to do it…' Time becomes *chronistic* and destructive: I lost my individuality to the progress of the past and even clock-time itself (Lindroos 1998; Keller 1999). With now-time, Benjamin hopes to rebalance past and present to provide an alternative to historicism that creeps up on us in surprising ways, for instance, in medical practice and education.

21.7 *Opportunities* in Medical Practice and Health Professions Education

Based on our outlined framework on time, we wish to address two issues in medical practice and health professions education. First, the *chronistic* clock allows us to seize control over our work, however, it also controls and dictates the lives of health professionals and medical trainees. There is much to do in little time, and that requires superb organisation skills, but *kairos* does not let itself be planned. We would not deny that *kairotic* moments never occur during busy days. Rather, we point to *kairotic* moments getting lost once they have occurred during a busy day because there is little time to let the potential force of the *kairotic* moment land. This is why we support taking time to reflect, for instance in scheduled 'reflection groups' (Veen and de la Croix 2017; van Braak et al. 2021). However, from the perspective of *scholê*, we must be aware that, at work, we are encapsulated in protocols, values, and norms that dictate our goals. We wish to reach goals because at work we are very invested in our roles as medical trainees or practitioners. This can invite typical (scripted) reflections (de la Croix and Veen 2018) that abide by our prescribed responsibilities at work (*ascholia*). *Kairotic* moments like Coccia's disturbing one or more lighthearted ones, signal opportunities to break free from the modus operandi. To pursue such opportunities, we can keep the idea of *scholê* in mind. Contrary to *ascholia*, in *scholê* we are freer from obligations and goals. We do not argue that this process is binary. We suggest that pre-scheduled reflections during worktime can more easily elicit reflections that stay safely within accepted parameters and socially desirable outcomes (Hodges 2015), but that being vigilant about the latter might free reflection, even when it is scheduled during work time.

The second point we wish to raise is related to the *chronistic*, linear and goal-oriented perception of reflection and learning that is sometimes prevalent in health

professions education. For instance, in health professions education David Kolb's 'learning cycle' is a widely acknowledged model for learning and reflection and has inspired other reflection and learning models (Veen and de la Croix 2017; Nguyen et al. 2014; Roessger 2014). What is particularly puzzling in these models, but Kolb's work in particular, is the conception of learning as both static and flexible (Coffield et al. 2004). They focus on learning as process, while simultaneously formulating a historicist fixed end-goal once the models are applied correctly.

In Kolb's model, learners initially belong to one of four learning styles. Any progression requires cycling through four learning phases, and each is related to one of four learning styles. Cycling through the phases successfully leads to expertise. Put simply, learners need to make sense of past experiences by reflecting upon them, then formulate a hypothesis, apply a technique to experiment, and assess its effect in practice (ibid.). Being an expert means reaching the 'integration stage' and drawing from all four learning styles (ibid.). Although Kolb's model has received extensive criticism (ibid.), in the case of skills acquisition one could assume that such a linear approach to use the past in light of the future might be effective. Nonetheless, the model becomes questionable because it also functions linearly on one's professional identity:

> The process of socialization into a profession (…) instils not only knowledge and skills but also a fundamental reorientation of one's identity. (Kolb 2015, 261; See Chapter 3 for in-depth discussion of professional identity formation and socialisation)

Kolb's model and those that draw inspiration from it (Nguyen et al. 2014) exemplify a historicist propensity. In the 'integrated life style' of the expert, Kolb argues,

> …we see complex, flexible, and highly differentiated life structures. These [high-ego-development] people experience their lives in ways that bring variety and richness to them and the environment. (Kolb 2015, 326)

Conversely, those who have not reached the integrated stage experience more conflict in life, are less flexible, less creative, and bring less variety to their environment because they are unable to integrate all four learning styles (Kolb 2015). Here, historicism's 'utopic' or 'dystopic' qualities are visible depending on one's success. On the one hand, the model provides some control over the learner's development if learners instrumentalize the past correctly; however, on the other hand, the model exerts control over the learner. The utopic end-goal comes with many positive qualities that any non-expert currently lacks. If learners fail to follow suit, they remain stuck in a dystopic 'low-ego-development'.

If we confront Benjamin's criticism of historicism with the goal-oriented reflection and ideals surrounding professionalism, we argue that becoming a professional is not as unidirectional as some theories would project it. One can schedule and practice suture techniques, but scheduling 'professionalism' is much harder. Professionalism has a certain unplannable nature to it, and in the formative moments "truth

must be brought to bear by an individual somewhere and somewhen" (Smith 2002, 56). Becoming aware of *kairotic* opportunities helps disrupt solidified truths (about ourselves, professionalism, doctors, and so forth) without unidirectionally projecting new, fixed truths into the future. "This mental presence emphasises the ability to intuitively prophesise on the present, not through the past, but from the perspective of the present" (Lindroos 1998, 40). Therefore, we suggest that we should speak, instead, of *professional (present-) awareness* (Weigel 2015). Following Benjamin's philosophy, historic facts are not questioned, but the interpretation of those facts result in ideas (about professionalism) that are reconstructed when past and present clash. If one is alert to *kairotic* flashes of now-time, they provide us with opportunities to either adopt or (re)constitute those inherited truths that make up medical practice. Consequently, the image of the ideal, professional doctor does not exist as a stable entity we inherit but is a contingent montage of images and ideas in the present (Wyatt et al. 2021). Such (re)constitution could happen in the moment itself or could be explored at a later point in time through reflection by oneself or with others to become sensitive to *kairotic* moments.

21.8 Conclusion

In this chapter we have argued that there is a relation between *chronistic* and *kairotic* experiences of time. Moreover, we have explained that there is a difference between *scholê* and *ascholia*. We have further unpacked *kairos* with the help of Benjamin's criticism of historicism as a linear appropriation of the past that determines the present and future. These considerations lead us to raise two issues within medical practice and health professions education.

First, *kairotic* moments can occur at any time and are of value. However, there is a danger that 'taking time to reflect' occurs only with predetermined goals in mind for the sake of our responsibilities at work. Taking time as *scholê* is a way to break free from this inclination. Faced with endless tasks and vast volumes of information, opinion and demands for health care workers, it is labour that engulfs us. When one task ends, the next one begins. By bringing tasks to an end and allowing ourselves to come to rest in *scholê*, we might give ourselves time to rethink the purely goal-oriented sequence of daily events that encapsulate us. Perhaps the *kairotic* moment, when it strikes, is a call for inaction by setting aside the endless list of tasks and goals and embracing freedom from tasks.

Second, we emphasise that *kairotic* moments can interrupt the tendency to reflect on professional development and the development of medical practice in an overly linear, deterministic, and teleological manner. Consequently, we recommend moving away from terminology that shrouds models of learning and reflection in terms of linear professional growth and development (Table 21.1).

Table 21.1 Practice points

1.	Learning theories, protocols, and strategies based on previously successful experiences are valuable, but theory cannot always cast a net over uncontrollable moments which require you to be open to unique circumstances
2.	Institutionalized, goal-oriented reflection is valuable, however, dare to embrace the opportunity *kairotic* moments provide you to reflect on your ideas that guide your everyday habits
3.	By bringing tasks to an end and allowing ourselves to come to rest in *scholê*, we might give ourselves time to rethink the purely goal-oriented sequence of daily events that encapsulate us
4.	The image of the ideal, professional doctor does not exist as a stable entity we inherit from the past but should be debated as a contingent montage of images and ideas infused by *kairotic* moments in the present
5.	Thinking *chronistically* isn't wrong or bad, and we should not abandon it; we require *chronos* for our organisational and historic understanding of our past, and it provides the space for *kairos* and a qualitative interpretation of our time

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Chapter 22
The Application of Stoicism to Health Professions Education

Alexander MacLellan, Megan E. L. Brown, Tim LeBon, and Neil Guha

22.1 Introduction

What do the alarm clock, the water mill, and the concept of democracy all share in common? Though this may sound like the opening line of a critical political joke, these inventions and concepts are factually united by their origin in ancient Greece. Though, as a society, we consciously engage with and appreciate alarm clocks, water mills, and democracy, there stand other facets of life in ancient Greece that have not received the same degree of active attention. Stoicism, an ancient Greek school of philosophy, is one such facet. A philosophy of life, Stoicism is a holistic worldview, an ethic which offers guidance on 'how to live'. The philosophy is widely misrepresented, particularly within medical circles, as an indifference, a detachment, a suppression of all emotions. This chapter challenges such interpretations, offering an overview of Stoic philosophy as described by the ancient Stoics, and considers how Stoicism may meaningfully inform health professions education and research today. Through this chapter, we explore the applications of Stoicism to the health professions, drawing upon this practical philosophy to offer concrete advice as to

A. MacLellan (✉)
Department of Psychology, University of Bath, Bath, UK
e-mail: akem20@bath.ac.uk

M. E. L. Brown
Medical Education Innovation and Research Center, Imperial College London, London, UK
e-mail: megan.brown@imperial.ac.uk

Health Professions Education Unit, Hull York Medical School, University of York, York, UK

T. LeBon
TalkPlus (NHS IAPT Service), Farnham, UK

N. Guha
Nottingham Digestive Diseases Centre, University of Nottingham, Nottingham, UK
e-mail: Neil.Guha@nottingham.ac.uk

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how concepts and practices in the field may be reconceptualised to advance education and practice.

22.2 What is Stoicism?

If you search for a definition of Stoicism in the Online Oxford English Dictionary (Oxford University Press 2021), two definitions are returned. The first considers stoicism with a lowercase 's', "the endurance of pain or hardship without the display of feelings and without complaint". It is a definition many will be familiar with, particularly within the United Kingdom, where the British public are often portrayed as a sober, unemotional people. The use of stoicism or stoic (utilising the lowercase 's') in common parlance is at the root of misunderstandings of Stoic philosophy within medicine and health professions education. The second definition provided is more pertinent to our discussion within this chapter, describing Stoicism with an uppercase 'S' as:

> …an ancient Greek school of philosophy… the school taught that virtue, the highest good, is based on knowledge; the wise live in harmony with the divine Reason that governs nature, and are indifferent to the vicissitudes of fortune and to pleasure and pain. (ibid)

Stoicism, as we present it, therefore, is a philosophy advocating a happy and fulfilled life is achievable by living virtuously.

22.2.1 History and Background

Stoicism is thought to originate around 300 BCE, with Zeno of Citium considered the first Stoic philosopher. Whilst currently, philosophy is largely thought of as a pursuit of a privileged few, Stoicism was a philosophy for the people. Taking its name from the *Stoa Poikile,* or 'painted porch', the open-air market in Athens where the philosophy was espoused, the Stoics thrust open the doors of happiness for everyone. Exported from Greece, the philosophy gained popularity in the Roman empire, with much of our current knowledge originating from the Roman Stoics. Over 500 years, Stoicism grew into one of the most influential philosophies of the Western world. Taught by freed slaves and practiced by kings, the fingerprint of Stoicism can be seen in much of what we see in the world around us today.

Historically, Stoicism grew from the teachings of Socrates, espousing that moral virtue is the highest good, and thus the path to happiness, or *eudaimonia.* Whilst often translated as happiness, *eudaimonia* is perhaps more accurately translated as 'flourishing', a distinction that will carry importance. To the Stoics, the message was simple: happiness and a good life can be achieved through the personal practice of virtue. This message must have been an incredibly empowering thought to those ancient Greco-Romans who would be regularly faced with pain, pestilence, poverty,

and death. Those suffering from the tragedies of the day were provided with a holistic philosophy and structure to exert some manner of agency over their experiences in a world which they had little control over.

It is thought many early and renaissance Christian writers were influenced by Stoicism (Ferguson 2003). Later philosophers would draw upon, revise, and even revile the Stoics, yet their cultural significance on Europe cannot be overstated. Many of the teachings and practices of Stoicism influenced modern day cognitive therapies (Robertson and Codd 2019). The world of the Classical Stoics would be an alien one, yet with the philosophy undergoing something of a renaissance, it seems to suggest the concepts remain relevant.

Since 2012, the Modern Stoicism movement, established by academics and psychotherapists, has aimed to engage the public and lead research into the Stoic philosophy, with annual 'Stoic Weeks' encouraging participants to engage with Stoic ideas and practices for a week, conferences and publications (LeBon in Ussher 2014). More recently, Stoicism has been taught as part of professional development for Cognitive Behavioural Therapy (CBT) therapists by one of the authors of this chapter (TL) and has been found to improve rumination and resilience in anxious populations by another (MacLellan and Derakshan 2021). It is perhaps understandable why there is a renewed interest in this philosophy, and though many ideas may be disregarded as familiar, upon careful consideration they may offer a structure to bolster wellbeing.

22.3 Core Tenants of the Philosophy

22.3.1 Dichotomy of Control

The simplest practical tenet of Stoicism is referred to as the dichotomy of control—the assertion that an individual only has control over their thoughts and their actions, and that it is, therefore, the primary concern of the individual to ensure these are as 'virtuous' as possible. Epictetus, a key figure in the Roman Stoics, opens his handbook with this very message, and an instruction: should something not be in our control, we should be prepared to let it go. There are layers of complexity in these few lines. Opinions, desires and even fears have been marked as directly under our control, when they can often feel anything but; and things we find ourselves seeking to influence, such as how others think of us or even our own physical health, have been rendered largely incidental, though we shall return to this later. Epictetus, as a former slave whose leg was cruelly broken by his master, was perhaps most sensitive to the vagaries of fate. A good life is not to be found in a positive reputation, perfect physical health, or substantial wealth, but in virtue and rationality. His guidance is simple, rather than try to control things we can't, focus on those things you can, and you will find yourself in a state of tranquillity. Developing a recognition of what

one can and can't control, therefore, is a key practice for the Stoic, and one we shall return to.

22.3.2 Therapy of Emotions

Contrary to current beliefs, the Stoics were not attempting to suppress emotions, but rather engage with and surpass negative ones. Stoics took a cognitive view of emotion, proposing that rather than an external event being the source of an emotional experience, it is how we as individuals interpret that event that causes the emotion. For example: we learn that a colleague has spoken badly about our abilities. A Stoic would respond by recognising that we have been told this fact, we have not been told we are harmed by it. If this idea sounds familiar, it may be because CBT re-labelled this Stoic idea 'cognitive restructuring', making it one of the linchpins of its evidence-based psychotherapy. This is far from the only technique used by the Stoics, with Robertson (2012) naming eighteen techniques used by Stoics in the management of emotions. Moreover, whilst modern CBT focuses more on *factual* misinterpretations leading to negative emotions (for example, challenging the thought that "people will ignore my colleague's comments') Stoics tended to place more emphasis on mistaken value judgements ("even if they don't ignore their comments, it can't really harm me").

Many of the emotions the Stoics spoke of (often translated as 'passions') are intrinsically linked with morality and were divided as either unhealthy or healthy based on their relation to rationality and virtue. For example, the unhealthy emotion of fear is rooted in the irrational expectation of harm, whereas caution, as the rational avoidance of true harm, is seen as a healthy emotion. The aim for the Stoic, then, is not to suppress, but to engage and understand.

22.3.3 The Virtues

The word 'virtue' has been used extensively thus far with little clarification. Virtue in this sense carries no religious connotation, but rather describes the expression of characteristics that we are uniquely able to display. The Stoics, therefore, would state that a human has virtue when they exert their capacity for self-control and reason. More specifically, the Stoics concerned themselves with the character virtues derived from Plato, each seen as being essential for success as a human being (Gill, in Ussher 2016):

- Justice is required to live well in communities
- Temperance to manage our desires
- Courage to overcome our fears
- Wisdom to underpin each of the other virtues and use our ability to reason well

These are often considered broader categories, encompassing more specific, related virtues, or character strengths.[1] For example, Justice would consist of fairness and equality, but also of kindness and philanthropy (Schofield 2003).

For a Stoic, the virtues act as a lens to view and regulate their own thoughts and actions. It is through the contemplation and cultivation of these virtues that a Stoic hopes to ultimately resist unhealthy emotional disturbance and navigate the world as a positive and productive member of a society. Indeed, for the perfect Stoic, living virtuously would ensure that one never had the temptation or the ability to suffer from unhealthy emotions to begin with. The Stoic, therefore, is tasked with developing a mindfulness not just of their thoughts, but of their character and through the development of one, the other will follow. The goal is not to simply do good things, but to be a good (or virtuous) person.

22.3.4 Moral Development and Cosmopolitanism

For the Stoics, acting virtuously was nothing more than acting according to nature, both human and physical. They believed that humans have a natural disposition to develop morally that is refined over the course of their life, as they gain greater control and practice with their faculties for reason. This sense of moral development is tied with the notion of *oikeiôsis*, translated as affinity or orientation. It is here, in this idea, that the cosmopolitanism of Stoicism is most apparent. The philosopher Hierocles writes of the development of morality as a process of achieving something akin to consistency both internally and externally. All animals, including humans, begin with an affinity with itself, the instinct of self-preservation. Further internal development comes with developing an awareness of, and consistency with, the virtues.

However, it is with external development Hierocles has had the most influence in the Stoic world. He proposed that the natural course of moral development was to extend one's affinity beyond just the self, to encapsulate wider and wider groups of people, until the whole human race would be treated with the same care as one gives to a family member. His advice included referring to those unrelated to you as 'uncle' or 'sister' (depending on their age and sex), at least internally, to engender a greater affinity with them. In the health professions, a similar effect is encouraged as trainees seek to develop an ability to connect with patients. With Stoicism often considered a rather self-centred philosophy, this idea of cosmopolitanism being an intrinsic part of moral development helps lend context to the politically active and socially engaged Stoics of the Roman era and provides a useful reminder for us in our daily lives.

[1] The VIA Institute on Character classification of character strengths lists 24 such strengths grouped into 6 virtues, which include the 4 Stoic cardinal virtues.

22.3.5 Theory of Happiness and Eudaimonia

Happiness, or *eudaimonia*, therefore, is the product of sound moral development by careful cultivation of the virtues. Although contemporary notions of virtue assume a dichotomy between ethics and prudence, many ancient philosophers saw no such division. Given the human condition, the qualities that are required both for personal happiness and for being an excellent human being are identical, these being the cardinal virtues. Virtue, therefore, is our best bet for happiness,[2] and one that is robust in the face of changing fate.

The Stoics recognised that when we place our idea of happiness in those things outside of our control, our lives would be far more affected by changes in fate than if we focused our concerns on those things within our control, namely cultivating virtues. In a world where you were far more exposed to shifts in fate than at present, the idea of gaining happiness from a possession would be a foolish one, when a storm could render you destitute. Of greater difficulty is the desire for positive relationships, respect, or physical heath.

The Stoic, then, is to accept both the positive and negative turns with equanimity. This may seem a cold and reclusive idea. Are we, then, to withdraw from our friends and family or possessions and the joy we derive from them as they may one day leave us or break?

No.

The Stoics recognised that humans naturally desire these things. Rather than change the nature of a person, they advise to consider what is being desired. Things considered outside of our control were classified as either preferred or dispreferred indifferents. Preferred indifferents are those which have some positive value (such as health and wealth) and dispreferred being those that are negative (such as illness and poverty). Should preferred indifferents come our way, we may enjoy them. Should they not, we accept this too.

This allows a Stoic to enjoy a possession but to remind themselves that it may break for it is fragile; to enjoy a relationship with a small reminder that it may end. Rather than take a pessimistic view that knowledge of something's impermanence would sully it, knowledge of transience allows for a greater appreciation of it whilst it is possessed. Happiness, therefore, is an acceptance of the things outside of our control, and an appreciation for what is currently had.

22.3.6 Worldview

We have primarily considered Stoic ethics thus far. However, ancient Stoics had much to say about Logic and Physics and embraced a worldview that may seem

[2] Not only did the Stoics insist there was no tragic tension between prudence and morality, they followed Socrates who argued in Plato's Euthydemus that virtue was both necessary and sufficient for eudaimonia.

strange to contemporary eyes. Most ancient Stoics were pantheists and determinists who believed in providence. They would have agreed with statements such as "the universe is a living thing" and "the universe is benevolent in its overall plan." Modern Stoics have debated how much of this worldview is necessary or helpful (Chakrapani and LeBon 2021). Some, like Irvine (2008), have described a version of Stoicism that does not rely at all on this worldview, and is the line taken in this chapter. Other modern Stoics have reinterpreted "living according to nature" to mean living what we understand the facts to be now (e.g., Pigliucci 2020). A reliable and readable introduction to a version of Stoicism which incorporates more Stoic physics than this chapter can be found in Sellars (2019).

22.4 Stoicism Within Health Professions Education

22.4.1 How Has Stoicism Influenced Health Professions Education?

The popularity of stoicism as a term has led to the cartoonish view that Stoic philosophy involves a cold, detached attitude to life and emotions—a 'stiff upper lip'—when, in actuality, Stoicism is a life philosophy that does not involve suppression of all emotions—rather, it concerns control of the negative emotions one will inevitably experience (Irvine 2008).

Unfortunately, within medicine, Stoic philosophy has been misrepresented as lowercase 'stoicism'. Though research drawing upon or referencing the philosophy is uncommon, the work that has been done usually considers stoicism in regard to patient experiences of pain, as a coping strategy in times of extreme physical distress, or as a masculine characteristic that explains certain behaviours or outcomes amongst men (Pathak et al. 2017). Such previous research is united by a conceptualisation of Stoic philosophy as stoicism, an indifference to pain and distress, or a non-caring, a nonchalance to serious issues of health. The Liverpool Stoicism Scale (LSS), a validated psychometric tool developed in 1995 and used within health research to measure 'stoicism' (Calderón et al. 2017), epitomises this cartoonish interpretation. According to the LSS, stoicism involves a lack of emotional involvement, dislike of emotional expression, and ability to endure emotion (Ribeiro et al. 2014). Indeed, one of the scale items participants are asked to rate their agreement with is the statement "one should keep a 'stiff upper lip'" (Wagstaff and Rowledge 1995). Though 'stoicism' is used throughout literature concerning the LSS, the very same literature contextualises the scales' use in the philosophy of the ancient Stoics. This amalgamation of two very different definitions of 'stoicism' and Stoicism has led to confusion within medicine at large as to the principles and applications of ancient Stoic philosophy. Given such a narrow definition and interpretation, there is much of the philosophy that is unexplored in relation to medicine, and which could cast interesting, new light on issues of contemporary interest in the field.

Within health professions education more specifically, Stoicism is largely unexplored in regard to the education and research of healthcare trainees and professionals. Where research has been conducted, this most commonly concerns Stoicism as a coping mechanism in difficult situations. Research conducted by Taylor et al. (2019) references stoicism with a lowercase 's' briefly in regard to one way in which medical students manage fatigue, whilst Papadimos (2004) explores Stoicism in a way truer to ancient texts as a coping mechanism to help practicing physicians cope with the emotional and social burden of caring for medical outlier patients. Recent research conducted by three of the authors of this chapter (AM, MB, and TL) has explored the translation of Stoic philosophy into psychological training for medical students, with the aim of promoting empathy and psychological 'grit' (Brown et al. 2022). Taking a somewhat different approach, Patro (2015) speculates the relevance of Marcus Aurelius' writings on Stoicism to medical student leadership development programmes, a hypothesis we could not see had been explored further. A lack of research and theoretical commentary in this area is notable, with published work sparsely cited, if at all. Similarly in regard to the field of medicine more broadly, there are many principles of Stoicism that remain unexplored within health professions education.

22.4.2 How Could Stoicism Influence Health Professions Education?

Given a relative paucity of Stoic research and theorising within health professions education, and the way in which the life philosophy has been misrepresented more broadly within medicine, there are many, diverse ways in which Stoicism could influence health professions education. For the sake of brevity, we consider three case studies of situations within health professions education where the principles of Stoicism we have outlined earlier in this chapter are relevant to considering contemporary practice, education, and research. All these case studies may be approached with similar practices, and thus there would be a degree of overlap. However, for clarity, we have restricted the practices explored to particular case studies.

22.4.2.1 Case Study 1: Dichotomy of Control and Theory of Happiness

Case Study 1: Sandra's Story

Sandra is a newly qualified doctor in her first week of work, caring for a patient with terminal cancer, Mrs Harrington. Mrs Harrington has no family or close friends, and so Sandra finds time to speak to Mrs Harrington every day and

enjoys speaking with her about her interesting and varied life. Mrs Harrington dies two weeks after first meeting Sandra. This is the first death Sandra has ever experienced as a doctor. She struggles to cope with the death of Mrs Harrington emotionally, thinking of her often and becoming upset regularly. She feels angry that Mrs Harrington spent her final weeks in hospital without receiving any visitors.

Sandra is struggling to adjust to an inevitable consequence of practice as a doctor—the death of a patient. This, sadly, will be a case familiar to many healthcare professionals, such is the nature of working with those who are unwell or frail. There are two core issues for Sandra here, 1. Dealing with death as an inevitable consequence of being a doctor; and 2. Dealing with issues of empathy and emotional attachment. This case study will focus on the application of the dichotomy of control and theory of happiness within Stoicism to the way in which healthcare professionals learn to deal with death.

Sandra is dealing with the death of a patient she has grown close to. We propose that considering the principle of the dichotomy of control may help. Ultimately, the death of some patients, particularly those with terminal diagnoses, is beyond the control of an individual—beyond Sandra's control. It may be helpful for Sandra to reflect on what she can and cannot control. She cannot control that Mrs Harrington has died, but she can control, with some support, perhaps, her own thoughts, fears and actions. Reframing in this way may engender a sense of agency in Sandra and increase her perceived sense of an internal locus of control, thereby increasing resilience in future situations where she may be faced with the death of a patient.

Stoicism's theory of happiness is also relevant. Firstly, as happiness is conceptualised as a product of moral development and cultivation of the Stoic virtues, Sandra may be reassured that engaging empathically with Mrs Harrison and taking the time to connect with her were virtuous, moral things to do that may lead to place a fulfilment in her professional future. Secondly, the Stoics conceptualise happiness as a product of living in accordance with nature—with fate. Placing one's happiness solely in things that are outside of our direct control, such as the longevity of a terminally unwell patient, leaves us vulnerable to being negatively affected by unpredictable changes in fate. As discussed previously, the idea of accepting negative turns of fate in regard to our relationships with other people may seem cold. The Stoics frequently wrote of the idea of becoming at peace with death and loss, *memento mori*, learning to view death as a neutral event. As a Stoic, Sandra would be advised to remind themself of an inevitable end in order to fully appreciate relationships whilst they are present and lessen the pain of their parting.

22.4.2.2 Case Study 2: Virtue Ethics and Moral Development

Case Study 2: Daanesh's Story

Daanesh is a nursing student on attachment to a hospital ward during the COVID-19 pandemic in 2020. He is studying in an area with high rates of COVID-19 hospitalization and death, prior to the development of an effective vaccine. He lives with his mother who has significant physical health issues. During COVID-19, the isolation of COVID-positive staff means that the ward Daanesh is placed on is short-staffed, and he is asked to work additional shifts to cover gaps in the rota. Daanesh is petrified of catching Covid and infecting his frail mother.

Here, Daanesh is reflecting on and processing the difficulty in balancing his responsibilities and duty of care towards his unwell mother, and the healthcare profession and community more broadly. In order to help Daanesh consider the difficult situation in which he finds himself, we will consider the relevance of Stoic virtues and the Stoic theory of cosmopolitanism to this case.

The notion of cosmopolitanism may be useful here. Exercises such as using Hierocles' concentric circles may ultimately help Danesh increase his affinity with those he does not know and so make him more willing to make himself and his mother vulnerable by working extra shifts. This could mean that he should work additional shifts and treat the patients and staff on his ward with the same care he affords his mother—yet, this is too simplistic.

Whilst Stoicism encourages people to extend their sympathies to others, unlike utilitarianism, it is not so demanding as to insist that they treat strangers with the same priority as those to whom they have closer affinity. There may be other ways that Daanesh identifies he could help those on his ward through social or political engagement.

In resolving his conflict, Daanesh may wish to reflect on the virtue of justice, which is comprised of fairness, but also kindness and philanthropy. Daanesh may consider kindness towards his mother, or philanthropy, as a sort of service towards the healthcare community and patients during a time of crisis. The virtue of wisdom may help Danesh reflect on which parties should take priority. Whilst this may not simplify the decision, this process of reflecting on cosmopolitanism and virtue may help Daanesh process his thoughts and reason his way through a troublesome decision.

22.4.2.3 Case Study 3: Therapy of Emotions

Case Study 3: Ywain's Story

Ywain is a registrar in medicine and has been a doctor for five years. They had a serious incident which led to a complaint being made about them recently from a patient. Even before this, they were having doubts about their career. Ywain is not sure if they should continue with medicine as a career.

The above scenario shows Ywain struggling with a decision regarding their identity as a doctor, a situation rendered more complicated due to the complaint brought against them. Whilst Ywain may have doubted their career choices previously, a catalysing event such as a complaint can bring these, otherwise natural concerns, to the fore, and cause personal distress. It is from this perspective we will consider how the Stoic therapy of emotions can be of use to Ywain in resolving this conflict.

As mentioned previously, the Stoic view of emotion is broadly similar to many cognitive theories of emotion, being that an external event (hearing a complaint has been made about us) is not the cause of an emotional experience, but it is our *interpretation* of that experience ('I should not be a doctor'), that causes the emotion (guilt and anxiety). Both Stoic and cognitive theories posit a largely uncontrolled first response, with a second response that involves either cognitive maintenance, or reappraisal. For example, upon hearing a complaint has been brought against them, Ywain may feel an initial somatic sensation and experience of anxiety. In both Stoic and modern cognitive models of emotion, Ywain may then maintain and reinforce this state with negatively valenced cognitions, e.g. 'I just do more harm than good' or 'I wish I could be like my friends who don't appear to struggle as I do'.

As a Stoic, Ywain recognises their response is within their control. Their first task, therefore, would be to reflect on whether their troublesome thoughts are factually correct, and to engage in a process of self-questioning their emotional responses, their motivations, and their assessments of these beliefs. They could ask those who know their practices best how they rate their competence. Ywain could be helped further by remembering that they can't control what other people think, and to attempt to let their opinion go. Ywain could contemplate their actions as either virtuous or not and use their reflection as a springboard for professional development, or as a recognition of an anxiety that needs addressing.

22.4.3 Stoic Research Tools

In this chapter we have endeavoured to showcase what Stoicism has to offer in practical modern contexts, such as the health professions. However, this field is still developing, and further research is required. Currently the Stoic Attitudes and

Behaviours Scale (SABS) represents the best quantitative measure of Stoic ideation, with validation currently ongoing.[3] At present, qualitative methodology represents the most reliable way to identify Stoic ideation in samples.

22.5 Practice Points

We hope this chapter has given you a working insight into how Stoicism might form part of your personal philosophy in your healthcare profession, and wider life. We also see transferability of these messages to educational practice, particularly within the landscape of reflective practice. To assist, we propose 5 practice points which may help you integrate some of the ideas we have discussed personally, but also within educational settings.

1. Differentiate between Stoic philosophy and emotional suppression—Stoicism as a philosophy has much to offer as an engaged practice, yet there is a requirement to distinguish and remove the stigma from the word due to the prevalence of the lowercase form 'stoicism'. This requires nothing but a mindful use of the word and acquainting oneself with the philosophy, as introduced to you by this chapter.
2. Reflect on what is in our control—with the dichotomy of control frequently returned to in Stoicism, our recommendation is that a reflection on the limits of one's control may form the basis of Stoic practice. This need not be cumbersome, but can be incorporated flexibly into a daily routine, or adopted as a response to stress. Educators may wish to trial this type of reflection within health professions curricula formally or informally.
3. Adopt a Stoic therapy of emotions—as detailed in the previous case studies, the Stoics would propose to take a moment to pause when confronted with distress and seek to understand the cognitions that play a role in their onset and maintenance. We would propose the same when taking part in clinical encounters, and in professional and personal reflection. Educators supervising students participating in clinical encounters could help guide students in this practice.
4. Look through a virtuous lens—the act of resolving both professional and personal dilemmas can be eased by consideration of the four virtues and which course of action best exemplifies them. This process may, again, find its place in reflective practice.
5. Extending affinity with groups—our final point is to suggest a conscious exercise of extending affinity to those in our professional lives. This may be done during professional reflection or during a private moment, but to follow the cosmopolitan ideals of the Stoic, one's aim should be to view the belligerent patient as a troublesome family member, or a frustrating colleague as one's difficult cousin (Table 22.1).

[3] See www.modernstoicism.com/research for full details of the SABS v5.0 scale.

Table 22.1 Practice points

1.	Differentiate between Stoic philosophy and emotional suppression
2.	Reflect on what is in our control
3.	Adopt a Stoic therapy of emotions
4.	Look through a virtuous lens
5.	Engage in the exercise of extending affinity with groups

22.6 Conclusion

This chapter set out to provide the reader with a primer in the philosophy of Stoicism and highlight some of the ways it may be incorporated into health professions and medical education. By necessity, much which may be of interest has been omitted as it is beyond the scope of this introductory overview. It is our hope that this chapter is the catalyst for further interest in Stoic philosophy. We would like to leave you with this quote by the Roman Emperor and Stoic Marcus Aurelius ([161–180] 2006):

> Objective judgment, now, at this very moment. Unselfish action, now, at this very moment. Willing acceptance, now, at this very moment, of all external events.
>
> That is all you need.

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Chapter 23
Teaching Dignity in the Health Professions

Bryan C. Pilkington

23.1 Introduction

Ethics education within the health professions varies greatly, but two approaches are most common: some rely on discipline—or profession—specific resources, such as codes of ethics for particular sets of practitioners (e.g., the American Speech-Language-Hearing Association code for Speech Language Pathologists or the American Medical Association's code of ethics for physicians practicing in the United States), others turn to the well-trodden arena of bioethics and (most often) adopt some version of principlism (e.g., appeals to the principle of autonomy in many medical school curricula).

This chapter offers to the reader a distinct approach, one rooted in the concept of dignity, and argues that, by attending to this concept, there is the potential to widen the ethical horizons of health professions students. An approach to ethics education in the health professions that takes seriously the concept of dignity does four things: first, it attends to the narrative nature of human beings and their self-conceptions, that is, their *stories*; second, it engages non-standard cases (cases less commonly discussed or cases considered to be at the margins of health ethics conversations); third, it embraces analyses of complicated concepts; fourth, it attempts to unify broad ethical considerations across the health professions and, in so doing, aims to serve as a potential focal point not only for the ethics of particular health professions, but also for interprofessional ethics.

B. C. Pilkington (✉)
School of Health and Medical Sciences, Seton Hall University, Nutley, NJ, USA
e-mail: bryan.pilkington@shu.edu

College of Nursing, Seton Hall University, Nutley, NJ, USA

Department of Philosophy, Seton Hall University, Nutley, NJ, USA

Department of Medical Sciences, Hackensack Meridian School of Medicine, Nutley, NJ, USA

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23.2 Story-Telling Animals

The philosopher Aristotle ([350 BCE] 1999) famously claimed that human beings were rational animals. Development within a broadly Aristotelian approach has advanced this view and, borrowing from the work of ethicist Alasdair MacIntyre (2007), describes human beings as story-telling animals. If this is correct, there are implications for health, healthcare, and the training of members of the health professions, e.g., in an encounter with a patient, reading their chart may be epistemically[1] insufficient, a narrative medicine (or narrative health) approach might be required. This is partly because human beings are not merely tellers of stories, but they think through stories and—if MacIntyre is correct—find themselves embedded within larger narratives through which they understand themselves or others and which impacts their health and the health-related decisions that they might make. This approach is also instructive for ethics educators of health professions students. Students come to professional training with their own stories and as bearers of particular and diverse traditions—family considerations, cultural traditions, personal reasons for seeking out a particular health profession, et cetera. Conceiving of patients and of students in this way can influence how education in health professions and the treatment of patients is conducted. To be more specific, this framing is suggestive of a principle, concept, or norm which ties not only to particular features of particular persons, but rather one which engages the wholeness of persons, lest the complexity of human life (and the relation of those many components of health) be missed. One candidate to fill this role is the concept of *dignity*. In later sections of this chapter dignity will be (briefly) contrasted with other approaches, but the aim of this chapter is not to defeat and replace ethical approaches that are more dominant in the ethics education of health professionals currently; rather, the aim of this chapter is to offer an alternative approach which educators of the health professions might find valuable in their teaching and in their practice.

23.3 The Concept of Dignity

The concept of dignity has a more international flavour and greater global appeal than some of its counterparts. It plays a prominent role in many international human rights documents and national constitutions, serving as the grounds for the treatment of others. For example, the Universal Declaration of Human Rights specifies that "all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood" (United Nations 1948). The health and ethics implications for such claims follow upon this acceptance of dignity and the framing of rights in terms of dignity. Additionally, Article 1 of the fundamental charter of the European Union states, "Human dignity is inviolable. It must be respected and protected" (Schmitt 2008). Dignity, in

[1] Of, relating to, or involving, knowledge.

serving as an ethical concept that grounds treatment of all people, applies inside and outside of healthcare encounters. Attending to this concept refocuses our moral gaze on the patients as persons, despite their vulnerable (or marginalized) status, because they are members of the same moral community as health professionals and must be treated accordingly. Something similar can be said of students and their teachers. The humanity of both practitioners and teachers as well as patients and students does the philosophical heavy lifting claims of dignity. As O. Carter Snead (2007) notes in discussing the United Nation's proclamations on the concept:

> ...'human dignity' denotes the concept that human beings are, by virtue of their humanity, owed a special degree of moral care and concern. The "respect for life" is a corollary of this principle, namely, that human dignity rightly understood imposes the obligation to act with a high degree of care in matters touching and concerning human life and, at the very least, enjoins harmful or exploitative practices in this regard. (54)

Three key characteristics define dignity. Attending to the dignity of patients requires practitioners (and all members of the health systems) to avoid humiliating patients, denying patients healthcare opportunities, and killing patients. In brief, attending to considerations of humiliation forces us to recognize the vulnerability (or marginalization) that patients bring to health encounters and serves as a resource for the argument that such recognition is essential to caring well. For example, strictly employing a "medical model" and conceiving of patients with, say, particular disabilities, is a kind of humiliation which ought to be avoided. Such an approach assumes the acceptability of certain societal structures as normative—it focuses on the landscape, not on the person. In a similar vein, classroom policies and practices which seek efficiencies at the costs of individual student attention can fail to attend to the anti-humiliation prohibition of respecting the dignity of health professions students. 'No laptop' policies with special exceptions or requirements to be "on camera" in online instruction are two examples. Singling out students who may need a laptop to read or 'see' the content or adopting a policy which forces students to open their rooms or homes and transforming extracurricular space into classroom space are measures that should be adopted with great care.

Denying people relevant opportunities is a second violation of dignity. This is because attending to dignity draws attention to standards connected to what it is to live a good human life, and from these standards, the necessary resources for the realization of such a life can be garnered. Though there is some disagreement about the content of those standards, a variety of approaches—such as Nussbaum's (2008) work on dignity and capabilities, Thomistic capacities-based approaches (George and Lee 2008), or even practical social policy goals, like the United Nations' Sustainable Development Goals (United Nations 2015)—are all examples of connecting the treatment of people to the kinds of beings that they are and working—either theoretically or practically—to ensure that the resources for this (or, negatively, to prohibit violations against their realization) exist. A common theme amongst all of these approaches is the importance of health, and so reflection on the concept of dignity is a natural fit for education in the health professions.

Consider, for example, the philosophical idea of recognition. Recognition of others as members, like oneself, of the same moral community is key to both

understanding and respecting dignity (to expand on this idea, see Chapter 5, which considers the concept of 'acknowledgment', and Chapter 22, which considers the role of affinity for others in Stoic philosophy). Because all human beings are such members, they are all entitled to care. Thus, within the field of healthcare ethics, special care is taken to avoid denying access to patients due to financial, social, or geographic reasons because denying the opportunity to access health resources that are needed for human flourishing is a violation of their dignity (for an expansive discussion of social justice, see also Chapter 9). Dignity is tied to membership status; it is not distinguished according to factors such as geographic location. This holds true for classrooms, as well. Recognizing students as dignified members of an educational community—and future members of a health profession—means offering flexible content delivery and implementing various types of evaluations. Health professions teachers should not seek to simply drop facts into the heads of students, but instead should aim to place these individuals in the best situations to succeed for themselves. Related both to ensuring opportunities and to prohibiting humiliation, health professions educators ought to shun as vigorously as possible old models of 'hazing' into a profession.

The final key characteristic of taking dignity seriously is attending to the prohibition on killing. Because human beings are members of the same moral community, they ought not—to take up the paradigmatic[2] example of a violation of dignity—be killed. This prohibition fits well with the care-focus of the health professions. To kill another is, in many ways, to abandon care. Though life and death considerations are not common within the daily practice of many health professions, it is still important to highlight this characteristic in an overall account of dignity, and in the teaching of dignity to health professions students. Patients are owed continued care and health professionals are barred from concluding that obligation by themselves ending a patient's life or abandoning a patient in other significant ways. Though no direct analogue exists in education, health professions educators ought to continue to care—in a pedagogical sense—for students even if they have failed an exam, plagiarized a paper, or acted dishonestly in a practicum. Jettisoning a person from a program, for example, is appropriate in some cases, but should be used as a last resort.

23.4 Murky Concepts and Getting Things Right

Dignity can be a tricky concept to teach. It can appear murky, or less straightforward, in the fast-paced world of healthcare. In an attempt to clearly consider how we may teach dignity, I reflect on dignity using the above description: 1. Broadly, as being connected with the kinds of beings that humans are, and the resources needed for those beings to flourish; and 2. Negatively, in terms of violations of dignity—humiliation, denials of opportunities, and killing.

[2] Serving as a typical example of something.

Though the aim of this chapter is to introduce dignity as a viable ethical concept for health professions education and not to defeat other options, to motivate its viability some comparisons may be useful. Some have argued that autonomy is the most important principle in bioethics (Post and Blustein 2015), a field which—as noted above—has had a great influence on healthcare ethics and ethical practices within the health professions, and especially within medicine, over the last 50 years (Evans 2014; for an in-depth review of the history of bioethics, particularly as it pertains to climate change, see Chapter 18). In fact, some theorists have argued against dignity in favour of autonomy on the grounds of the utility of each concept (Macklin 2003). The charge of futility is levelled against dignity because it is said to do no more than the concept of autonomy and, with Ockham's razor hanging overhead, it could be surmised that we might as well stick with what we know. Though healthcare and instruction in caring for health have benefited from reflection on autonomy—informed consent being the chief practical good derived—it is not sufficient, nor are the other famous three principles of bioethics (justice, beneficence, and non-maleficence) (Beauchamp and Childress 2019).

To illustrate this, consider a case of humiliating treatment: the all too common case in medicine where, after seeing a patient and leaving the room, a physician makes a joke about the patient's appearance to the care team. They all laugh and move to the next room. Most find this to be bad behaviour; some might describe it as unethical, some as unprofessional, but it is not a violation of autonomy. It is, however, a violation of dignity. This patient was thought of and treated as something less than what they are—a human being—and though this may not affect their care, it affects how they are seen and understood. Suppose that they were to come to learn of the joke; this may negatively affect their self-conception and, potentially, impact their overall health outcomes, even if it does not affect the healthcare they receive. Even if they are aware of what was said and even if they are hurt by it, if they still have decisional power over the kind of care they receive and if that care is available to them, then this would not be a violation of autonomy (or of justice, beneficence, or non-maleficence—at least as traditionally understood in this field). Similar cases exist in education. Teachers who joke about their anonymous students' performance on exams or written assignments—"how could someone think x"—do not violate a student's autonomy. However, this kind of derision should be avoided because it highlights that the educator is conceiving of the student not as a person, as a member similar to themselves, but as an object of a joke. It raises—as it does in healthcare—whether a proper relationship between teacher and student or practitioner and patient exists.

Part of the challenge of introducing a new concept in ethics education in the health professions is, as the aforementioned critics note, that there are other concepts that are well known and understood to be useful. However, new concepts can bring benefits of new realizations and of extending the ethical horizons of students. In the very least, new concepts offer the ancillary benefit of welcoming consideration of non-standard, or less commonly discussed, cases. It is to such a case that we now turn to further illustrate the usefulness of dignity.

23.5 Non-Standard Cases and Spaces

Attending to the health of large groups, as opposed to particular individuals, is an increasingly discussed task for members of the health professions and a great deal of work in public health ethics exists to help guide this work. However, less thought has been devoted to particular populations whose vulnerability is exacerbated during times of pandemic, e.g., incarcerated persons. Reflection on the position of the subjects of mass incarceration—an especially ethically problematic situation in the United States—is, though challenging and weighty, an excellent case study for teaching dignity to health professionals. The othering that is involved in incarceration, at least as it is practiced in the US, is both a violation of dignity and also instructive to those interested in an ethic that takes seriously the vulnerable state from which many patients seek aid from healthcare providers.

Incarcerated persons are often conceived of as mass and not as unique, individual members of the human community. This was highlighted early in the COVID-19 pandemic when it was reported that:

> … 1,828 people — or 73% of all inmates — have tested positive for COVID-19 at the Marion Correctional Institute in Marion County, Ohio, according to the Ohio Department of Rehabilitation [and] Corrections…At least 2,400 inmates across Ohio state prison facilities have received positive diagnoses for COVID-19 since Ohio Department of Rehabilitation [and] Correction began testing on April 11…As of April 22, incarcerated people make up 20% of the state's entire coronavirus cases. 12 inmates have died. (Bates 2020a)

Systemic problems affect individual people (for more on the relationships between individuals and groups, see Chapter 14 on the debate between individualism and holism), and the failure to treat incarcerated persons as dignified, and so to attend properly to their health, has plagued these individuals. One such person, Raymond Rivera, was:

> Arrested on a minor parole violation and sent to Rikers Island, where he waited months for a final decision on his release. As his case dragged on the coronavirus spread through the jail complex and he became sick. On Friday, state parole officials finally lifted the warrant against Mr. Rivera as he lay in a bed at the Bellevue Hospital Center. He died the next day. (Ransom 2020)

Spending time at the same complex led to the death of another man, Michael Tyson. "He had been in custody at Rikers Island over a technical parole violation—a non-criminal violation, like missing a curfew or failing to report an address change to a parole officer" (Bates 2020b) for a month, when he contracted COVID and died. This lack of attending to the health of dignified persons occurs in a context in which others are treated differently. A final example highlights the othering of those who are incarcerated in New York, and those New Yorkers who are not:

> "The day after Gov. Andrew Cuomo ordered New Yorkers to stay home and maintain 6 feet of distance from one another, corrections officers handcuffed 33-year-old Jose Diaz to another man by his wrist and ankle and put them on a bus headed to Rikers Island, where the coronavirus had already infected more than three dozen detainees and jail employees…. The pandemic has hit Rikers harder than the rest of New York City. At least 91 inmates

> for every 1,000 have tested positive for Covid-19, compared with 16 residents per 1,000 citywide. The top physician at the jail complex has called the situation a "public health disaster unfolding before our eyes" and urged the release of "as many vulnerable people as possible." As another Rikers doctor put it, "The only meaningful intervention here would be to reduce the jail population." (Brown 2020)

It is complicated to address whether specific violations of autonomy have occurred in these cases. This is because, in part, the autonomy of incarcerated persons is restricted and understood to be so. However, as members of the same moral community, the extremely risky health situations that persons were placed in is unethical. Neither because their movements were restricted nor because their time was taken from them, but because they were not afforded the necessary opportunities related to their health that would allow them to flourish as human beings. Reflection on non-standard cases[3] like these has the potential to open up the horizons of health professions students to attend more to the structures that either aid, or impinge upon, their patients' attempts to live healthy lives. The failure to attend to the dignity of those mentioned in these cases was catastrophic: it left some dead, some without opportunities to be safe and to thrive, and others in the humiliating position of being at the whims of systems to which they had no recourse. Three specific lessons can be drawn from a focus on dignity and reflection on the health-related situations of persons residing in institutions of incarceration, and it is to those lessons that we now turn.

23.5.1 Lesson One: Retaining Dignity

There are a variety of treatments which, though they aim at (and the hope is that they will realize) health, place people in situations that are potentially humiliating, reduce their opportunities, or risk their continued existence. These situations can be exacerbated by the overarching power dynamic embedded within many health encounters given the divergence in knowledge between patient and practitioner, and the sheer fact of vulnerability and dependence of a sick person asking for aid from a health professional. Informed by dignity, we might ask: can patients leave the hospital experience, or complete the recommended treatment, with dignity? Such a question might also be asked regarding certain "tough" or hazing-like practices within some health professions in order that trainees will be able to "make it" through challenging situations.

Health professions students and educators might consider Dirk van Zyl Smit's (2010) description of prison conditions and ask if the institutions and spaces in which they work or plan to work allow for all patients to retain their dignity:

> At its best, concern about prison conditions is motivated by the recognition that prisoners as *human beings* have a right to *dignity* that should be recognized notwithstanding their

[3] Incarceration is a commonly discussed case, but in research ethics, not in ethics education in the health professions.

> incarceration. Regulation of prisons may seek to determine whether prison conditions are such that prisoners can live in prison in a way that allows them to *survive with their dignity and humanity intact* and, ideally, improve themselves in the process. (503)

23.5.2 Lesson Two: Undignified Treatments

Patient-centered care is a common mantra in the current healthcare landscape, but are there procedures, policies, or healthcare structures which aim to benefit practitioners at the cost of patients? The need for protection of practitioners, whether in terms of their own conscience or their very bodily integrity (as the lack of PPE in some places during the COVID-19 pandemic has made clear), is an accepted norm, but one which must be justified when others bear the burdens of that protection. Secondly, might there be particular kinds of treatment that simply should not be engaged? Health professions students and educators should reflect on Priscilla Ocen's (2012) expressions of concern about labour and delivery in prison:

> Even when pregnant prisoners are provided medical assistance during labo[u]r and childbirth it is often at the expense of their dignity and basic humanity…Instead of approaching the pregnancy and childbirth of incarcerated women with dignity and respect, the childbirth process is often an occasion for particularized punishment, degradation, and humiliation. Prison officials frequently justify the use of shackles on pregnant prisoners by citing concerns for the safety of correctional officers and the public. (74)

Health professions students might reflect on Ocen's description and ask if they are truly hearing and seeing their own patients? Is their diagnostically essential skill of listening as well-honed as the other tools in their diagnostic toolbox? In a healthcare landscape in which women and, in particular, mothers, are not as seen and as heard due to obstacles such as structural racism (Smith 2019), does this example of incarcerated women suggest any changes in the practices of the health professions? Might reflecting on a case where the ethical issue is not simply that persons were not allowed to make a decision about their care, but rather that they were humiliated and treated in a way that does not befit the kind of beings they are, alter students' outlook? Health professions educators might ask structurally similar questions as they reflect on their assignments, evaluations, and their overall pedagogical approach—are their aspects of their curriculum which benefit them at the cost of their students?

23.5.3 Lesson Three: Recognition

Recognition of another person as a member of the same moral community, especially while delivering news or engaging in shared decision-making, is essential for good healthcare. Good and bad news is often delivered by health professionals and even more prevalent are the opportunities to engage in shared decision-making about the course of treatment and health goals. How news is delivered matters; how patients

are "consented" matters; and to do so well and ethically is aided by the recognition that the patient is a member of the same moral community as the deliverer of the news or the consenter. A useful analogue comes from Michael O'Hear's (2012) work on incarceration:

> A large body of procedural justice research teaches that the process through which a legal decision is made may matter as much, or even more, to the people affected by a decision than the content of the decision. In particular, a legal process that treats participants with dignity and respect may promote respect for the law and legal system, even if the substance of the decision is adverse. (223, emphasis authors' own)

Health professions students might reflect on how the recognition of the dignity of a patient helps to reframe conversations in which bad news is shared, a medical error is disclosed, or a costly but beneficial treatment is recommended. They might entertain the classic philosophical question: could I have been someone else? Considering such a question might aid students in adopting a different perspective. Recognising another as similar to oneself in the relevant ways helps answer ethical questions about error disclosure, the manner in which information is shared, and the importance of shared decision-making because it raises a kind of reciprocity—not in terms of the practitioner-patient relationship—but in terms of a deeper human connection within society, wherein a health professional can see themselves as being on the other side of the exam table. A similar question can aid health professions educators as they teach students who may "come to age" in their shared profession in a different time and context than they themselves did.

23.6 The Unifying Ethics of Dignity

Attending to the dignity of others in healthcare contexts refocuses the gaze of health professionals from the treatment of an appendix in room 456, a torn anterior cruciate ligament in room 789, or a case of autism in 123, to the treatment of someone like them. The universality of this approach, dependent on the idea that all human beings possess dignity, is not without difficulty. There are two challenges to employing this framework: first, given that patients, as all human beings do, vary greatly with respect to their personal characteristics (for good and for bad), how can such a universal notion be workable in healthcare? Second, given that the practices of health professionals from physicians to athletic trainers, from occupational therapists to nurses, from speech language pathologists to physical therapists, all vary—their scopes of practices, histories of their professions, the areas of health and of the physical person that they focus on—how can such a universally applicable notion as dignity capture the nuance needed to inform health professional practice and to be used in the teaching of health professions students? These are important challenges to address. In some ways, they mirror the more standard ethical resource options—principlism and disciplinary-specific ethics resources (e.g., a profession's code of ethics), respectively—available to the health professions.

The first challenge is a conceptual one, and a weighty one at that. In clearly articulating an account of dignity and the standards of human flourishing by which to understand health practices and applicable resources, we open up the concern that people might not meet such standards. In some ways, this mirrors the debate over rights to health and rights to healthcare. If the former cannot be guaranteed, does it make such a right impossible or are many of us failing in our duties when someone does not achieve health? Another way of describing this challenge is to ask how a concept that is so particular, in applying to individual persons, can be universally applied?[4] Thankfully, in applying the concept to health professions practice and education, additional resources are at our disposal. These resources are of two types. First, in their focus on the physical and mental states of persons, the health professions bring with them a conception of healthy human life. They need not entertain this challenge internal to the concept of dignity for it to be a worthwhile concept to reflect on and to guide their practice. Universality can be found in the athletic trainer's treatment of a patient's broken leg on a practice field or the paediatrician's treatment of flu symptoms in a young child—though they are distinct persons, standards of health can guide health professionals, especially once they recognize their patient as like them.

This leads to a response to the second challenge, as well. Dignity is broadly applicable to all humans and its prohibitions on humiliation, denials, of opportunities, and killing are, as well. However, how each concept is actualized within different health professions—and within ethics education therein—may vary. It may be humiliating for an athlete, in certain circumstances, to be carried off a field, and so the athletic trainer who upholds the dignity of her patient may seek additional persons to help walk the patient away as opposed to calling for a stretcher. The speech language pathologist who recognizes dignity in her patient may not take a young student out of recess for therapy, but instead find a quiet time during the day to engage her and avoid the humiliation that can accompany being "pulled out." The occupational therapist who recognizes the dignity in her patients may broaden her horizon and work to alleviate negative social determinants of health or positively to empower her patient to contribute to bettering the social structures that might restrict her. Building a health professions ethics can, thus, be both universal and also particular. Recognition of another human being is the foundation of this ethic and how it is particularized is up to, in part, individual health professional practices as they treat individual, unique persons. The same can be said of a classroom environment. It is the treatment of human beings as less than what they are—as mere members of a mass of othered individuals—which tempts many to ground treatment of others on what Martin Luther King, Jr. ([1963] 2021) called the "solid rock of human dignity".

[4] Elsewhere, I describe this tension between *merit* and *equality*. I argue that accounts of dignity appeal to a concept with an inherent tension between an egalitarian notion that applies to all persons and a meritocratic notion that highlights the best activities of persons or the best versions of themselves.

Table 23.1 Practice points

1.	Consider employing non-standard cases and thinking from non-standard spaces in health professions education
2.	Reflect on the humiliation prohibition of dignity in your teaching and practice
3.	Aim to place patients and students in positions to flourish by affording them more opportunities, not fewer
4.	Reflect on the abandonment of care prohibition in your teaching and practice
5.	Promote dignity in your teaching and your practice

23.7 Conclusion

This chapter offers a new approach to ethics education in the health professions. It suggests framing ethics content in terms of dignity and, in particular, urges health professionals to avoid three violations of dignity—treatment that is humiliating, denies opportunities, and kills. Dignity's applicability is broad enough (with its focus on human beings) to be relied upon in the ethics education of a variety of health professions, but also specific enough (with the three prohibitions) to supply useful content for the practice of individual health professions. The details of this application must be put into practice by health professionals themselves as they realize dignity in their daily work. An important and ancillary benefit of this taking up a new approach to health ethics education is its suggestion of non-standard cases and spaces for reflection; this chapter focused on situations of incarceration to elucidate three lessons for health professional, which centered on practices that retain dignity, avoid undignified treatment, and call for recognition (Table 23.1).

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Chapter 24
The Ambiguities of Humility: A Conceptual and Historical Exploration in the Context of Health Professions Education

Barret Michalec, Frederic W. Hafferty, Nicole Piemonte, and Jon C. Tilburt

24.1 Introduction

> …there are little things that instructors would say here and there that encourage you to remember the greatness of what you're doing or how serious it is that you can take someone's life in your hands. And those things are true I guess but it breeds a sense of greatness that's just kind of gross, you know. It's just sort of sickening, and a huge turn off in medicine in general. But you're around that all the time and the fact of the matter is that you do have people's lives in your hands so to not feel that way at all is difficult.
>
> *First Year Medical Student, quoted in* Michalec (2012, 8)

The quote above from Michalec's (2012) study of socialization processes within medical education indirectly highlights the concept of humility. Although (as we will discuss later) humility has been linked to patient health, the limits of care delivery, and to patient-centered care, the role(s) of humility within health professions education has yet to be fully unpacked. We suggest that this hesitancy may stem from a lack of clarity regarding the concept of humility and what it means to be humble. Within this

B. Michalec (✉)
Edson College of Nursing and Health Innovation, CAIPER, Arizona State University, Phoenix, AZ, USA
e-mail: barret.michalec@asu.edu

F. W. Hafferty
Division of General Internal Medicine and Program in Professionalism and Values, Mayo Clinic, Rochester, MN, USA
e-mail: fredhafferty@mac.com

N. Piemonte
School of Medicine, Phoenix Regional Campus, Creighton University, Phoenix, AZ, USA

J. C. Tilburt
Division of General Internal Medicine, Mayo Clinic, Scottsdale, AZ, USA

Biomedical Ethics Research Program, Mayo Clinic, Rochester, MN, USA

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chapter, we examine the socio-historical evolution of the concept of humility in order to lay the foundation for future humility-oriented research and program development within health professions education.

24.1.1 The Ambiguities of Humility

Amongst contemporary scholars, there appears to be general agreement that humility is a socially valuable attribute. Not only is being seen by others as being humble or having humility perceived as socially beneficial, but humility is also seen as related to other positive attributes such as empathy, generosity, and open-mindedness, and to promote social cohesion (Snow 1995; Bollinger and Hill 2012; Exline and Hill 2012; Nadelhoffer et al. 2017; Weidman et al. 2018; Worthington et al. 2018). Yet, humility has a darker side to its apparent social desirability. Humility is also associated with self-abasement, low self-opinion, a sense of worthlessness, incompetence, small mindedness, shame, servility, lack of self-confidence, and a lack of ambition (Wright et al. 2018; Tangney 2000; Roberts and Cleveland 2017; Exline and Geyer 2004).

Taken together, these countervailing views suggest that humility possesses a conceptual duality, or, at the very least, a significant degree of conceptual *ambiguity*. What are the historical roots of the concept of humility, and where do these ambiguities of humility arise? Moreover, and specific to this chapter, how is humility discussed within the healthcare fields and within health professions education? How is humility presented and taught (informally and formally) to health profession students?

In this chapter, we address these questions by providing background on the conceptual and theoretical foundations of humility specifically related to philosophy and philosophical inquiry. Although we spotlight the prominent backdrop of virtue and virtue ethics as it relates to humility, we also examine the potential "costs" associated with humility, particularly as they pertain to health profession students. In doing so, we explore the current focus of humility in healthcare and health professions education, with particular attention to the arena(s) of interprofessional education.

In his recent chapter, "*I am so Humble!*", Robinson (2020) meticulously dissects the 'Gordian Knot'[1] of paradoxes associated with humility, including the apparent dichotomy associated with humility regarding low self-assessment and inattentiveness to one's status. In the same spirit, we suggest that exploring the dynamic history of the concept of humility through antiquity, the enlightenment and today is much like unraveling an intricate string of Christmas lights. You unravel a few sections only to come upon compounded knot after knot…after knot. Aside from carefully dissecting particular positions and deciphering complex prose about humility, it is essential to inspect specific challenges to scholars' readings of texts. Therefore, in

[1] The term "Gordian Knot" is often used as a metaphor for a complex, intricate, perhaps unsolvable problem. It is featured in a myth associated with Alexander the Great (i.e., "cutting the Gordian knot").

order to provide a grounding to our exploration, we begin by presenting the *current general understanding* of humility. We then travel through time to briefly examine how prominent historical and contemporary thinkers discuss humility and/or similar constructs. Our goal within this chapter is to advance the examination of humility as it relates to health professions education and cultivating the healthcare workforce of the future. Therefore, by providing a firm "base camp", while addressing the ambiguities associated with humility, we can then explore if, and how, humility is discussed within healthcare and health professions education.

24.2 Current Perspectives on Humility: A Grounding

To date, the conceptual and theoretical applications of humility have primarily been conducted through the disciplines of philosophy, theology, and psychology, with newer fields such as positive psychology and leadership science expanding this base (Alfano et al. 2020; Worthington et al. 2017; Tangney 2000; Sousa and Van Dierendonck 2017). This chapter will focus primarily on *philosophical* approaches to humility. However, across humility's multidisciplinary landscape, prominent scholars have provided historical explorations of humility with detailed accounts of its conceptual and theoretical evolution, evaluations of contemporary measurement techniques, as well as discussions outlining similarity and differences to related concepts (i.e., modesty, empathy, gratitude, etc.), along with the development of conceptual-cousins such as intellectual humility, cultural humility, and relational humility (see: Snow 2020; Davis et al. 2010; Van Toneren et al. 2019; Tervalon and Murray-García 1998; Foronda 2020; Wright et al. 2016, among others).

Across this landscape, Worthington Jr. et al. (2017) note, there is no universal definition of humility, and all definitions of humility are "up for debate" (344). Regarding a cohesive conceptualization of humility however, we can turn to psychology and subdisciplines therein. Tangney (2000), for example, provides a widely accepted broad overview of the key elements of humility that include: the *accurate* assessment of one's abilities and achievements as well as the acknowledgement of one's limitations and gaps in knowledge. In addition, being humble involves a relatively low self-focus, appreciation of others' contributions, and recognition that one is but a part of a larger universe (Tangney 2000). Similarly, Peterson and Seligman (2004) conceptualize humility as a process of self-evaluation that involves a non-defensive willingness to see oneself accurately (in regards to strengths and weaknesses) and the ability to transcend beyond self-focus and understand or view oneself from a broader perspective.

At the same time, as noted earlier, these more positive renderings of humility are not the only framing, and thus we must account for this bifurcation. Although there is evidence of the ambiguities of humility in psychology, sociology, and other disciplines, philosophy and philosophical inquiry, especially related to virtue-ethics, provides a roadmap of sorts to how the concept of humility evolved over time, and spotlights key transitions and "reversals" that lend to the ambiguities of humility. We

now step into our time machine to briefly connect with historical philosophers and spotlight their perspectives on "humility".

24.3 Historical Explorations of the Humility Concept

24.3.1 Classic Greek

Although Socrates (through Plato) never uses the term "humility" explicitly, Rawson (2005) provides a detailed discussion of Socrates' notion of "human wisdom" and its potential connection to our current understanding of humility.

Taken aback by an oracle's suggestion that no one was wiser than Socrates, Socrates sets out to have meaningful discussions with reputable politicians, playwrights, and others known for their moral and scientific wisdom to showcase how others are, indeed, wiser than he. Through his pressing interviews however, Socrates exposes holes in their logic and their explanations of beliefs. Rawson (2005), explains:

> The more expertise people claimed about the most important things in life – justice, virtue and the best way to live – the less they could justify their claims. Even the knowledge some people did possess, like the art or science of their trades, was overshadowed by their mistaken belief that they were also qualified to tell people how they should live. (31)

Socrates concludes that the key distinction between those he has met with and himself is that, whereas they believe they know something and clearly do not, Socrates knows nothing and knows it. In turn, Socrates interprets the oracle's comment to mean that the wisest is the person who is fully self-aware of their *lack* of wisdom—like Socrates. Socrates then sets out to promote this humble self-knowledge as he debates teachers, statesmen, and other prominent scholars of the time, cross-examines them with cutting questions and exposing their inconsistencies. In this sense, Socrates, without directly raising the concept of humility, may serve as a prime exemplar of humility (specifically intellectual humility, which we will discuss later), and his notion of "human-wisdom" as reflective of humility in its opposition to arrogance.

This caution against going beyond one's limits (i.e., keeping within human bounds broadly speaking) and avoiding hubris (or "hybris") is a consistent moral and theme throughout classic Greek writings. From Icarus flying too close to the Sun, Narcissus drowning in the lake, to Homer's Odysseus and his arrogant triumph over the Cyclops, it is clear that classic Greek thinkers valued the notion of accurate self-judgement and understanding (and accepting) one's limitations. According to Chappell (2020), although the term "humility" is absent within classic Greek philosophy, it is this avoidance of overreaching or overstepping one's bounds that rings closest to our current notion of humility. Yet, within classic Greek philosophy, there also is an ideological distance between arrogance (i.e. overstepping or stepping outside of one's human bounds) and proper pride and honor, and it is this ideological distance that problematizes humility during this era.

One aspect of this distance is apparent in Aristotle's discussion of virtues in *Nicomachean Ethics*. Although the virtuous man is aware of his constraints, the temporary nature of his achievements, and to some extent his privilege, Aristotle also argues that presenting or promoting oneself as less-than is insincere and in opposition to magnanimity—which he held in the highest of regards (Chappell 2020). According to Roberts and Cleveland (2017), Aristotle's notion of magnanimity (i.e., "megalopsychia") is somewhat akin to pride and "makes people sufficiently attentive to the honors that are due them for their greatness…" (38). In this sense, magnanimity serves as a middle-ground between arrogance/vanity and smallness/lowness. In this way, those who present themselves to peers as less worthy of honor are to be considered small-minded and the opposite of the "great-souledness" that is aligned with the virtue of magnanimity.

This notion echoes through ancient Greco-Roman ethics. To some extent, 'humility' is equated with an avoidance or dismissal of honor, a downcast of pride, and, within this frame, in opposition and detrimental to human potential and achievement.

24.3.2 Christian Philosophy

Continuing our (excellent) adventure through time, to the ancient Romans, merit-based pride, power, and honor were the highest of attributes and to be celebrated privately and publicly. In turn, humility (and related concepts therein) was related to shame, weakness, and abasement.

Yet, within ancient Judeo-Christian texts, there is evidence of a shift in the utilisation of term humility (Dunnington 2016). To this point, one may speculate that the term humility may have been purposely "reversed" by Judeo-Christian leaders (from Greco-Roman "paganism") to promote and encourage the oppressed, marginalized, and *humbled* Judeo-Christian people. This possible "reversal" within the Judeo-Christian philosophy and theology denotes a key shift in the use of humility as a *positive* attribute. Moses, a figure of authority and prominence, is venerated as "…very humble, more than all men were on the face of earth" (Numbers 12:3). And within classic Christian theology, perhaps no act is portrayed as more humble than Jesus' death—in fact, the acts and personification of Jesus as told through Judeo-Christian texts, are described as models in humility that followers should embrace and emulate. Moreover, within these writings, humility is framed as the antithesis to pride—with pride now conjoined with arrogance, envy, and conceit. Humility, in ancient Judeo-Christian philosophy, is framed not only as the antidote to pride, but also as an essential *virtue*.

For classic Christian philosophers, humility is necessary to be receptive to divine action. As Saint Augustine (Augustine of Hippo) states,

> if you should ask me what are the ways of God, I would tell you that the first is humility, the second is humility, and third is humility. Not that there are no other precepts to give, but

> if humility does not precede all that we do, our efforts are fruitless. (St. Augustine, cited by Dormor 2019)

Dunnington (2016) states,

> for Augustine, humility is fundamentally the embrace of radical dependence. Radical dependence is the will to receive completely one's being from the generosity of another and the will to give of oneself completely for the being of another. (27)

Dunnington goes on to state that for Augustine, humility is the transformation of one's will, to "desire differently". Augustine suggests that it is through humility in which all other virtues are cultivated and that humility, not pride, leads to excellence and happiness (McInerney 2016). For Augustine, humility is the centerpiece for virtue, and argues that 'pagans' (i.e., ancient Greco-Romans) cannot be genuinely humble as they are victims of various vices resembling pride. Of note, while the Romans used the cross as a tool to humiliate, Christian theologians utilize the cross, and the notion of Jesus' death on the cross, as the ultimate greatness and the true symbol of humility—and this is reflective in Augustinian philosophy (Dunnington 2016).

Further reflecting the central role of humility for Augustine is his commentary on the story of David's slaying of Goliath, "Humilitas occidit superbiam"—humility has slain pride. Augustine's approach to humility, as one of the highest of virtues, heavily influences how humility is perceived, and it in turn utilized in future Christian philosophical work. Although prevalent in other Judeo-Christian texts, Augustine consistently and emphatically distances humility from pride, presenting pride as the opposing force of radical dependence—and in turn an anchor keeping from divine connection. Augustine states (McInerney 2016):

> We are striving for great things; let us lay hold of little things, and we shall be great. Do you wish to lay hold of the loftiness of God? First catch hold of God's lowliness. Deign to be lowly, to be humble, because God has deigned to be lowly and humble on the same account, yours not his own. So catch hold of Christ's humility, learn to be humble, don't be proud. Confess your infirmity, lie there patiently in the presence of the doctor. When you have caught hold of his humility, you start rising up with him. (2)

This notion of being subjugate in order to ascend is also prominent in the works of Saint Benedict (Benedict of Nursia), who suggests humility is the ladder to which we ascend into heaven, a ladder that we must first *descend*. The 12 rungs of the ladder are discussed in the *Rule* for monastic life and are framed by Porter et al. (2017) as:

> …submission of one's will to divine commands, regular confession of one's shortcomings to a trusted elder, a grateful acceptance of one's work assignments, and food allotments, and the strategic use of silence geared toward cultivating solemnity. (57)

A strong supporter of Benedicts' 12 degrees of humility, Thomas Aquinas sustains the virtuous nature of humility, but presents it more as a restraint of sorts, a model of temperance to navigate our appetites (i.e., urges, desires, concerns) in a reasonable and moderate manner. Humility keeps us in-bounds, prevents us from going beyond our limits, and is a reminder of divine rule and reverence for and subjugation to God.

Put simply, to Aquinas, humility pulls the reins back on pride. Again, we see this notion of humility as tether, keeping us within our limits—keeping us grounded. For Aquinas, "Humility is a limiting mechanism, like a governor on a gasoline engine that prevents it from being revved up beyond safety standards…" (Roberts and Cleveland 2017, 39).

However, in addressing Aristotle specifically, Aquinas also argues that humility and magnanimity are actually complimentary virtues (Newman 1982).

> Here is Aquinas's paradox: no humility, no true or full magnanimity; no magnanimity, no true or full humility. Demean or jettison humility, then, and regardless of your intentions you have dealt a deathblow to greatness of soul. (Keys 2008, 218)

Moreover, Aquinas argues that humility is good for society in that it promotes the common good and civic engagement. This notion also echoes the works of St. Bernard of Clairvaux who suggested that humility is true self-knowledge, and that the recognition of our own flaws and limitations (through humility) endear us to be beneficent, forgiving, and gentle with other people.

As Newman (1982) notes, "In analyzing humility, Aquinas and other religious philosophers emphasize the importance of subjection to God. In their view, all humility is rooted in this basic subjection" (282–3). In this sense, Christian philosophy frames humility as the converse of pride, vanity, and conceit, and ties humility directly to a submission of the self to God. Dunnington (2016) argues that the notion of humility emerged from a Jewish-Christian outlook, and that a "…challenge confronting secular philosophy is to give an account of humility that does not rely on presuppositions unique to a religious outlook" (19). This "challenge" is somewhat more evident among contemporary philosophers (as we will discuss later in the chapter), as prominent scholars emerging from the Enlightenment appear to take *substantial* efforts to untangle humility from its Judeo-Christian roots, even to a dramatic extent in certain cases, and in turn, further cultivate the ambiguities of humility.

24.3.3 The Enlightenment

The Enlightenment represents less of an aggressive or hostile attempt to eradicate religion from socio-political thought and practice, than it does a collective effort to emphasize and promote *human* potential and capability. This shift from the sacred to the profane is well reflected in the use of and perspectives on the concept of humility in the philosophical writings of the time.

According to Cooper (2010), Thomas Hobbes engages with the concept of humility from a socio-political framework, situating humility as a stalwart for durable social stability in that it is through humility that all humans are acknowledged as equal—through an awareness and appreciation of human capabilities and limitations. In *Leviathan*, Hobbes makes a distinction between confidence and pride (i.e.,

glory in one's former actions), and "vainglory" or an inaccurate self-estimate. Moreover, within this conceptual framework, humility for Hobbes is an awareness of one's own vulnerability and finitude, and by association, the acknowledgement of other humans as naturally equal. Although Copper highlights Hobbes' empowering frame of humility, she also credits Hobbes with the new/next "reversal" of how humility is utilized in philosophical writings through his need to extract religious-based notions of humility from how humility can exist within socio-political philosophy. Dunnigan (2016) outlines Copper's stance noting that for Hobbes, humility is no longer a virtue that "…facilitates divine-human relationship", but rather is framed as a vehicle "…to inculcate the knowledge of finitude that Hobbes thought was a precondition for the sustainable collective agency" (30).

Whereas Hobbes' writings may present a somewhat favorable view of humility (albeit from a socio-political standpoint), David Hume truly "…vilified humility as keeping people mired in weakness and inaction" (Worthington Jr. 2017, 79). Hume frames humility as limiting and undercutting ambition and attempts to reinstate pride as a key virtue that fuels human agency and purpose. Hume refers to humility as a "monkish virtue", a term he uses for various traits associated with self-denial such as celibacy, fasting, silence, and solitude that masquerade as virtues (Davie 1999). Hume argues that these traits are in opposition to the flow of human life, and in turn, humility should actually be considered a vice, an "…'indirect' passion of self-deprecation" (Keys, 2008, 218). However, Burch (1975) argues that, "By 'humility' Hume means the feeling of humiliation, embarrassment, or shame. He does not mean the character trait of humbleness or modesty" (177). Burch suggests that it is from this framework that Hume positions humility and pride as opposing forces.

The positionality and role of humility in Immanuel Kant's moral theory are not only challenging to decipher but, in turn, also debated within the philosophical literature. Although not often considered a "virtue theorist", Kant argues that pride is essential to moral virtue, and although he connects humility to desirable aspects of self-esteem, Kant is vehemently opposed to the false-humility of servility, as well as Christian accounts of humility in general (Grenberg 2005; Louden 2007). An advocate for the centrality of humility in Kantian ethics, Grenberg (2005) argues that Kant viewed humility as the "..meta-attitude which constitutes the moral agent's proper perspective on herself as dependent and corrupt but capable and dignified rational agent" (133). In fact, Grenberg argues Kant's stance on humility can be interpreted as: since inaccurately assessing oneself (i.e., self-aggrandizement) is at the heart of social ill, then constraining over self-valuing and appropriate reassessment (i.e. humility) is positive for societal function. For Kant, true humility (i.e., "humilitas moralis") follows from our comparison of ourselves with the moral law (rather than moral *agents* such as Jesus), and our embracing of and respect for the moral law. Furthermore, from this internalization of moral law stem "feelings of inner worth" and self-esteem (Louden 2007, 632).

Like Hume, Friedrich Nietzsche is adamantly consistent and complete in his rejection of humility. Humility is at the heart of morality of servitude and unnatural devotion, a self-protective instinct of the weak and powerless (i.e., "slave morality") (Nadelhoffer et al. 2017). For Nietzsche, humility serves as a barrier against

humanity's progress as it leads us astray from noble powers of mastery and undermines the raw nature of our wills to dominate (i.e., 'master morality'). Nietzsche explicitly problematizes the Christian stance on humility, even stating that the religions of the world that tout humility as a virtue were propagating a lie that it is virtuous to *not* strive to your fullest potential to *not* embody greatness (Bollinger and Hill 2012). Bollinger and Hill (2012) frame Nietzsche's perspective:

> Since these less fortunate individuals cannot attain the power and resources needed to obtain happiness, they twist their powerlessness into a virtue and proclaim it as a desired end in itself. In this way the weak try to stymie the strivings of the strong by proclaiming that humility, not power, should be the desired goal. (31)

From Hume and Nietzsche, we see the de-virtueing of humility—tying humility to weakness and subservience, and even categorizing humility as a vice, arguing that it thwarts human progress and potential. Although the Enlightenment-era "reversal" of the conceptualization of humility is quite clear with Hume and Nietzsche (feeding the ambiguities of humility), the shift for humility as a vice *back* to a virtue (i.e., the *general common understanding* of humility) is not so obvious. Yet, the humility-as-a-virtue position is a consistent and persistent stance within the current philosophy literature—which, yet again, further cultivates the ambiguities of humility.

24.4 Contemporary Accounts of Humility

Garcia (2006), Snow (2020), and Roberts and Cleveland (2017) each provide condensed profiles of prominent contemporary philosophers' primary stances regarding humility, as well as evidentiary fodder for a broader glimpse into their reasoning. Nonetheless, and because of the nuances nested within the variety of current humility conceptualizations, we will present a general overview of a few key voices in the field, then outline the consistencies among these conceptualizations that may bring us to the *current general understanding* of humility that we offered at the beginning of this chapter.

For Snow (2020), Taylor (1985) serves as a likely bridge between historical and contemporary perspectives on humility. Channeling Aquinas, Taylor argues that humility serves as a restraint for humans to not overstep or overreach their human-bounds. For Taylor, having humility and being humble means an acceptance of one's lowly position, but does not include self-abasement. Moreover, Taylor (1985) does not extract pride from humility:

> The humble who occupy and accept a lowly position on some hierarchical scale may be merely poor and meek. But to be virtuously humble is not to accept meekly just any sort of inferior position. (17)

Norvin Richards (1988, 1992) rejects Taylor's account of humility arguing that if only those who accept a lowly position can be considered "humble" then those who have attained a high position are excluded from being "humble". For Richards

(1988), humility "…involves having an accurate sense of oneself, sufficiently firm to resist pressures toward incorrect revisions" (254) (i.e., thinking too highly of oneness). Richards emphasizes the need for knowing oneself so well that you have no motivation to exaggerate yourself. In short, with Richards' notion of humility, you can avoid thinking too highly of yourself without the nasty after-taste of low self-respect.

Utilizing modesty and humility somewhat interchangeably, Julia Driver (1989) suggests that modesty, which from her perspective relies on ignorance, is "…a dogmatic disposition to underestimation of self-worth" (378). To Driver, the modest/humble person is someone who not only ignores their good qualities and achievements but is also *ignorant of* them. Put simply, modesty to Driver (2001) is almost an absent-mindedness to one's own merits and abilities—a self-forgetfulness and an un-noticing.

According to Snow (2020), humility is "…the disposition to allow the awareness of and concern about one's limitations to realistically influence one's attitudes and behavior" (11). Snow's approach to humility is more concerned about awareness and acknowledgement of one's weakness, rather than an accurate understanding of one's strengths. Through her two types of humility, she outlines how humans can be appropriately concerned with the flaws associated with the self (narrow humility) as well as taken aback by limitations associated with acknowledging human existence in the broader sense (existential humility) (Snow 1995, 2020).

Garcia (2006) states that humility is virtuous as long as stems from desired self-improvement and/or proper acknowledgment of others' deeds and merits:

> The humble are those who are unimpressed with their own admired or envied features...those who assign little prominence to their possession of characteristics in which they instead might well take pride. They are people for whom there is little personally salient in these qualities and accomplishments. (417)

Like Garcia, Roberts and colleagues (Roberts and Wood 2007; Roberts and Cleveland 2017) promote an understanding of humility through what *it is not*: pride, self-importance, envy, conceit, and self-righteousness:

> The virtue of humility is intelligent lack of concern for self-importance, where self-importance is construed as conferred by social status, glory, honor, superiority, special entitlements, prestige and power. (Roberts and Cleveland 2017, 33)

Roberts and colleagues believe that someone can be humble and acknowledge their greatness—it is the lack of concern for this greatness (the void of self-importance) that is the key.

Despite variations, there are certain consistencies within contemporary philosophical approaches to humility. These conceptualizations often tout a heightened awareness and knowing of the self, along with a willingness to be open to one's own limitations (and strengths). Taken together, these conceptualizations also speak to an accurate and congruous understanding of one's flaws and merits, but also a sense of security in one's vulnerabilities.

Thus far, we have engaged with classic and contemporary philosophy to explore the journey of the concept of humility, and to better understand the ambiguities of

humility through apparent "reversals" of humility that have, in turn, shaped its more contemporary conceptualization. But how is humility applied and activated within the health profession fields and health professions education?

24.5 Humility and Health Professions Practice and Education

The majority of discussions of humility within the health professions literature (practice and education) are commentaries, editorials, and snapshots of practice-based experiences that are framed as reflections on practicing humility and/or being humbled. These offerings typically highlight the beneficial nature of humility in care delivery, nesting it within "professionalism" and praising humility as an important trait to teach (formally and informally) to health professions students (Li 1999; Hader 2008; Oxman 2012; Mammas and Spandidos 2019; Caruso Brown 2019; Petriceks 2020). Although there have been efforts to extrapolate and apply the concept of humility within the realm of care delivery (Crigger and Godfrey, 2010; Cleary et al. 2014; Zinan 2021), and most recently care delivery during COVID-19 (Cosgrove and Herrawi 2021; Décary et al. 2021), it was not until recently that the impact of practitioner's humility on patient health began to be explored (Ruberton et al. 2016; Huynh and Dicke-Bohmann 2020; Watkins Jr. and Mosher 2020).

Regarding conceptualizations of humility offered within the fields of care delivery, Coulehan (2011), presents an idea of humility through four attributes: unpretentious openness, avoidance of arrogance, honest self-disclosure, and modulation of self-interest, and suggests that, within medicine, humility "…manifests itself as unflinching self-awareness; empathetic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for a sick person" (Coulehan 2010, 200). In his discussion of the feedback processes related to Competency-Based Education (CBE), Gruppen (2015) highlights the role of humility,

> Humility is a willingness to acknowledge the possibility that you are fallible and may be wrong, that you need guidance or help from others on occasion, that you can benefit from feedback, and that you need to make changes in your performance. (6)

Chochinov (2010) defines humility by what it is not, "Being humble, however, does not mean embracing mediocrity or indecision, any more than clinical confidence need be conflated with arrogance or hubris" (1218). Following Crigger and Godfrey (2010), Dameron (2016), suggests, "Humility is not about being self-critical. Instead, it is about an honest appraisal of our faults and shortcomings" (9). Notably, particular voices in these fields, such as Crigger and Godfrey, Paine and colleagues, Grouper, and Coulehan, among others, do refer to humility as a virtue which not only aligns with various contemporary philosophical perspectives, but echoes classic Christian theology.

Given psychology's strong presence in the evolvement of humility as a concept, humility theory, and the measurement of humility, it is not surprising that there is an

active conversation within the practice of psychology and psychotherapy regarding the role of humility in patient care and mental health services (for review see: Worthington Jr. 1998; Paine et al. 2015; Davis and Cuthbert 2017; Sandage et al. 2017). Moreover, Paine et al. (2015), offer the concept of *Clinician Humility*,

> …the evolving inclination toward accurate self-assessment, recognition of limits, the regulation of self-centered emotions, and the cultivation of other-centered emotions in a clinical setting. (10)

According to Paine et al., clinical humility (as well as humility in general), like other virtues can be practiced and honed—they suggest through deliberate reflection, study, and practice.

Another fruitful humility-oriented arena within health professions literature has been discussions of humility's conceptual cousin *Cultural Humility*. Distinguishing cultural humility from cultural competence, Tervalon and Murrag-Garcia (1998, 117) state that cultural humility is:

> …a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. (117)

Smith and Foronda (2021) offer "ground rules" to teaching and cultivating cultural humility within the classroom, and although their proposal is directed primarily at nursing and nursing education, their approach could certainly be expanded to include students of other health professions. Relatedly, Agner (2020), as well as the American Occupational Therapy Association (2020), outline the value and importance of practicing (and teaching the tenets of) cultural humility within Occupational Therapy. Moreover, Foronda and colleagues continue to explore and expand the conceptual, theoretical, and operational parameters of cultural humility (Foronda et al., 2016, 2021; Foronda, 2020).

Intellectual humility, however, has received far less attention within the health professions fields. We briefly raised the concept of intellectual humility earlier in this chapter in our discussion of Socrates and his notion of "human wisdom". Davis et al. (2016) state that intellectual humility "…involves (a) having an accurate view of one's intellectual strengths and limitations, and (b) the ability to negotiate ideas in a fair and inoffensive manner" (215). Of note, Gruppen (2014), connects the notion of intellectual humility to elements of the Hippocratic Oath and highlights the value of respecting the skills and knowledge of colleagues.

Within the broad fields of healthcare delivery and health professions education, there appears to be a consistent stance that humility is valuable to patient care and as a trait (perhaps even skill) to cultivate among current and future practitioners. Moreover, there appears to be alignment between these conceptualizations of humility within these fields and the conceptualizations stemming from the contemporary philosophers provided earlier (e.g., Richards, Snow and Roberts)—perhaps even hints of Christian philosophical approaches to humility as well in the framing of humility as a virtue. Nonetheless, there is a dearth of research and theoretical and conceptual explorations of humility (in the general sense) within the healthcare

fields. There is an abundance of research and conceptual explorations associated with *empathy* (Sulzer et al. 2016; Michalec and Hafferty 2021), so why is humility being *humbled*? Crigger and Godfrey (2010) offer two possibilities: (a) if understood in the narrow sense of humility as lowliness and unworthiness, this conflicts with modern societal conceptions of self of having value and importance, and (b) the potential linkage of humility in the religious sense (i.e., Augustinian-Christian frame) may stifle empirical engagement with the concept of humility. Below, we offer an additional hypothesis—given humility's implicit and explicit tether to social status (Michalec et al. 2021), and the volatile nature of status dynamics as they relate to practitioner-patient and practitioner-practitioner interactions, humility is a sticky-wicket for scholars in these fields to navigate.

Relatedly, many scholars offer examples of organisational, and even national-level, barriers to cultivating and practicing humility within the healthcare fields such as: challenges embracing "medical uncertainty", perceived power and control in decision making, a national culture that values individualism and hubris, embedded informal and formal competition (associated with exam scores, placements, opportunities, etc.), a "publish or perish" culture within organisations regarding job security, the imperial status of clinical knowledge, structures that implicitly and explicitly discourage collaboration, and an overarching culture that dissuades vulnerability and openness (Gruppenf 2014, 2015; Chochinov 2010; Coulehan 2010, 2011; Li 1999; Zinan 2021). There are also individual and interpersonal-level challenges nested within the healthcare fields and educational systems therein that may stifle the cultivation and practice of humility among providers and students. Gruppen (2014, 56) suggests, "Cognitively, humility comes at a price of confidence and clarity. The task of perpetually entertaining the possibility that one is wrong is demanding" (56). Moreover, although humility is generally understood as a positive social attribute, given the ambiguities of humility there is the possibility that humble people might be perceived by others as unassertive and lacking confidence and in turn, have their work mistakenly attributed to others (Owens et al. 2012). Furthermore, as Michalec et al. (2021) argue, there are informal and formal social expectations regarding *who* should be humble and *when* individuals should exhibit humility (i.e., regarding race, ethnicity, gender, socioeconomic status, among other status characteristics), and failure to follow these expectations could have dire consequences regarding (social) sanctions such as isolation and withholding of various resources.

Overall, humility is still very "young" in the health professions and health professions education literature, specifically in regard to measurement, evaluation, and impact on patient health outcomes. Within this burgeoning scholarship, in regard to the conceptualisation of humility, there appears to be implicit (and perhaps explicit) nods to classic Christian philosophy (e.g., Aquinas), as well as more contemporary philosophers such as Richards, Snow, and Roberts among others—yet the "voice" of specific Enlightenment thinkers, such as Hume and Nietzsche, is somewhat muffled, if not absent. Moreover, there is no evidence of "ambiguities of humility" within this particular scholarship, as there is apparent consensus within the health professions

literature that humility is a positive attribute (perhaps even a virtue), and a practice-based skill to cultivate and promote. However, the "how" aspect of promotion, particularly given the traditionally high value (perhaps even virtue) of confidence within the culture of medicine (i.e., "fake it 'til you make it") renders the picture still more opaque than clear. As noted above, our goal within this chapter is to advance the examination of humility as it relates to health professions education and cultivating the healthcare workforce of the future by examining the socio-historical evolution of the humility concept. However, given the relative "new-ness" of humility within the fields of care delivery and health professions education, we encourage continued excavation and exploration of not only the *what*, but also the *when*, *where*, and *how* of humility. Below, we offer some potential next steps to address these questions.

24.6 Moving Forward

Along with current recent efforts regarding measuring the impact of providers' degree of humility on patient-related outcomes (Huynh and Dicke-Bohmann 2020; Ruberton et al. 2016), and the effectiveness of particular humility-based interventions on individuals' attitudes and behaviors (Watkins Jr. and Mosher 2020, 2017; Lavelock et al. 2014; Ruberton et al. 2017; McMahon 2020), we suggest three other areas that are ripe for future humility exploration.

First, there is abundant literature regarding the nature of feedback in health professions education. In line with current research on the processes, techniques and best practices associated with feedback, scholars can explore if and how humility is utilised by both interaction parties to facilitate feedback, as well as differences related to cultivating humility and improperly 'accepting' humiliation, especially as it relates to health professions education and students' wellbeing (Shah et al. 2020; Kupfer 2003). Similarly, future research in this area can examine potential connections between humility, feedback and shame, belittlement, and bullying. Moreover, such research could be expanded to include how tenets of humility (and being humble) may be reflected in reflection and reflection-based processes frequently touted within health professions education.

Second, there is a great deal of attention and voice paid to the influence of the imposter phenomenon (or 'imposter syndrome') on health profession students' and young professionals' socio-emotional well-being and productivity (Prata and Gietzen 2007; Christensen et al. 2016). Because the imposter phenomenon's foundational focus is an *inaccurate* view of oneself, their accomplishments, and their knowledge, future work should examine the potential connection between humility and the imposter phenomenon (Slank 2019).

Finally, given that team-based, collaborative care promotes more effective and efficient care delivery, it is important to explore how health professionals and health profession students learn to respect, value, and appreciate those outside of their own discipline/practice. Somewhat similar to Paine et al.'s notion of clinical

humility, Michalec attempts to expand the concept of humility to the interprofessional realm and has recently proposed a 'Professional Humility' concept (Michalec 2020). Professional humility represents a consistent ability and willingness to: (a) evaluate, account for, and respond to the occupational status hierarchy within health professions (and health professions education), (b) understand the strengths and limitations of one's own profession, and (c) accept and acknowledge the qualities, skills, knowledge, and aptitudes of health professions and care team members including patients and caregivers. Michalec's professional humility addresses individual and organisational-level challenges to humility, while also situating it in advancing the practice of team-based care and interprofessionalism.

24.7 Conclusion

Like a feather in the wind, the concept of humility is subject to both light breezes and blusterous gusts within the realm of philosophical inquiry. However, as Chappell (2020) suggests, "…because in investigating any virtue, humility included, we must always keep in mind that real virtues are not timeless essences but sociological and psychological realities" (188). In addition, Chappell advises readers to examine the context of how time-specific socialization processes and mechanisms may influence our understanding of 'virtues'. This points directly to the nature of the ambiguities of humility and how shifts and reversals in how humility is conceptualised speaks to larger socio-cultural factors. In turn, perhaps the most important thing to remember regarding humility in care delivery and health professions education is not its status as a virtue, but rather how humility is perceived within practice and education. How humility is referenced within lecture halls and clinical sites may reflect time- and location-specific notions of 'professionalism' as well as serve as a canary for organisational culture as suggested in the quote that opened the chapter. Hence, exploring philosophical perspectives of various topics in health professions education not only highlights gaps in our understanding, but also the ambiguities of particular attributes and traits that we may often take for granted (Table 24.1).

Table 24.1 Practice points

1	Given the ambiguities of humility, explicitly unearth how humility is conceptualised within your organisation. How does organisational leadership and faculty perceive humility as it relates to patient care—and how does this conceptualization trickle down to students and their professionalization
2	Decide within your organisation if humility is a valued trait/process for health profession students to learn and cultivate—and if so, develop formal programs of practice to promote humility among leadership, faculty, and students
3	Explore if and how humility is reflected within interprofessional settings (including interprofessional education courses and programs)—this may resemble intellectual humility and/or professional humility
4	Take note of biases and stereotypes associated with humility and being humble as they relate to gender, race, ethnicity, socioeconomic status, and other status characteristics—as they may influence how particular students are treated, evaluated, and promoted (or not)
5	Advance the scholarship associated with humility and care delivery and health professions education. Use this chapter as a stepping stone to examine various social situations where humility and being humble may be active or necessary. Such research can further expand our understanding of what humility 'looks like' in various situations as well as identify other barriers and facilitators to humility (and being humble) among practitioners and health profession students

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Chapter 25
Concluding Remarks

Megan E. L. Brown, Mario Veen, and Gabrielle Maria Finn

Each of the chapters in this volume has examined how a philosophical perspective can be applied to an area in health professions education (HPE). These chapters have not been exhaustive but provide an accessible introduction to HPE in three ways. First, each chapter stands for a whole field in philosophy that could be drawn on to illuminate a HPE theme and has hopefully provided suggestions for further study and exploration. For instance, there is much more to be said about bioethics as well as climate change, but in this volume, both are addressed in Chapter 16 as green bioethics, and in Chapter 15, which focuses specifically on how to integrate ethics teaching in education. Second, each chapter is necessarily the application of one philosophical perspective, where there could be many other ways of addressing that issue. For instance, there are any number of educational philosophies that could be applied to the philosophy of education, just as there are perspectives besides Stoicism and Existentialism that could illuminate identity in HPE. Third, the list of topics that could—and arguably should—be addressed is not exhausted by the chapters in this volume. While our chapters did address social justice and feminism, we did not address LGBTQIA+ issues explicitly. From the perspective of philosophy, the chapters in this book have emphasized *continental* philosophy more than analytical philosophy, and *Western* philosophy rather than Eastern philosophy.

M. E. L. Brown (✉)
Imperial College London, London, UK
e-mail: megan.brown@imperial.ac.uk

M. E. L. Brown · G. M. Finn
Hull York Medical School, York, UK
e-mail: gabrielle.finn@manchester.ac.uk

M. Veen
Department of General Practice, Erasmus University Medical Center, Rotterdam, The Netherlands
e-mail: m.veen.1@erasmusmc.nl

G. M. Finn
University of Manchester, Manchester, UK

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These omissions are inherent in the limitations of such a volume, as well as the positionality of the editors and the selection of authors. In the following, we would like to give a (again, non-exhaustive) summary of the themes addressed in the volume, identify recurring/overarching practice points, and highlight some of the themes that were threads journeying between our chapters. We will also offer thoughts regarding themes that could benefit from additional perspectives, such as the ones we have mentioned above.

This volume does not tell a single story, but rather takes the form of a dialogue: between HPE professionals and philosophy, but also between the different chapters in this volume. One way to illustrate this is by taking a single concept and exploring its journey through the chapters. Here is one attempt to tell—not *the* story of this book but *a* story—the story of *agency*.

The concept of agency denotes the difference between what is happening to me and what is happening through me, between what I do and what is done to me. But, in the health professions, it is also about how to relate to others' agency, especially when those others—students or patients, for instance—are in a dependent position in relation to us.

The first four chapters are about education, which inherently poses a challenge to agency because who is the agent in the original translation of *education* as *ex-ludere* or 'to lead out': the one who is educated, or the educator? How do we reconcile the goal of education to churn out autonomous, authentic health professionals with the necessity that this imposes a structure on trainees that they have not invented themselves? Chapter 2 describes how these questions are resolved in the philosophical concept of *pedagogy*, which creates meanings and indicates purposes, pointing in a direction rather than laying out strict guidelines of what education should look like. Pols and Berding conclude that one of the most important things HPE may learn from philosophy of education is "the importance of trust in a student's capability to form themselves, the importance of self-activity, and of a safe place to be educated in".

In Chapter 3, Verwer and Van Braak further develop this notion of students' agency in education through critiquing the emphasis of Professional Identity Formation on *socialisation* rather than what they call *subjectification*. In HPE, individual students are trained to become qualified in health care practices and, in doing so, become part of a community of practice. There seems little sense of agency in these two aspects of education, because qualification means to meet a certain standard, becoming skilled in a practice, and socialisation means becoming part of—and conforming to the norms of—an "already existing order" (48). In contrast to these "pre-moulded trajectories of development" (50) that conceptualize students as objects ('identities' to be developed), they propose introducing the concept of *subjectification* in addition to Professional Identity Formation to acknowledge students as beings in the process of becoming a subject, that is, enacting agency.

But how do we enact agency—how are we free—in the context of the restrictions imposed on us by the world? Chapter 4 explores how Simone de Beauvoir's idea of freedom as embracing ambiguity could serve as an alternative model for Professional Identity Development. By reconceptualising ambiguity not as something to merely

tolerate, but as something to embrace as the basis of any ethics or value system, Veen and Brown describe how the highest stage of freedom for de Beauvoir "involves social and political action to liberate the oppressed". In other words, *my* agency is contingent on the degree to which I promote *others'* agency. This chapter on existentialist philosophy lays out a number of issues that will need to be addressed in order to truly develop this idea of agency, which are explored in subsequent chapters: how can we address *social justice* in HPE?; what does this mean for the physical aspects of HPE, such as learning to heal *bodies*?; how do we deal with the ambiguity of *technology* in HPE as simultaneously creating new possibilities, and hence promoting freedom, while also closing down these possibilities through techniques and skillification?; and how do education and philosophy relate to the factual, scientific, or *ontological* features of the world?

But first, Chapter 5 describes a practical approach to doing justice to ambiguity, the need for subjectification, while enacting one of the central 'skills' (a concept this chapter challenges) of HPE: *empathy*. De la Croix, Peters and Laughey argue that "the life-giving gift of acknowledgement" (80) is a much-needed practice in HPE because it does justice to the patient's voice while simultaneously creating "a clear space where students feel welcome as their whole selves, including their everyday concerns and contingencies" (86).

They also, however, describe the tension between complex concepts such as empathy on the one hand, and the requirement of HPE to assess students' progress. Indeed, the relationship between education and assessment has always placed tension on agency. How can we say that, on the one hand, students need to develop their identity on their own accord, being free and embracing their unique way of being a healthcare professional, while also doing justice to the societal demand for qualified professionals whose skills we can trust? Chapter 6 traces the philosophical shifts in health professions assessment. Tavares, Pearce and Eva point to the fact that there are always assumptions and intellectual frames underlying assessment, and that it is never simply a manner of accurately representing a pre-existing state of affairs. Being mindful and critical of our guiding assumptions underlying assessment also means taking into account "the impressions of assessment recipients and the broader social context in which the assessment takes place" (109) which could be seen as a way of saying that assessment needs to acknowledge and be respectful of students' agency: assessment not simply as something being done *to* them, but also *through* them.

So far, issues regarding the broader social and political context in relation to agency have come up several times, without explicitly being explored in depth. Perhaps surprisingly, the concept that serves as a hinge to explore these issues is often seen as the antithesis to concepts: the *body*. We largely treat the body as something that 'is what it is'. Nothing seems more obvious than the question 'what is the body?' —but philosophy is a practice of questioning the obvious. In Chapter 4, we have already encountered the ambiguity of the body: it is both the site of agency—the site from whence I act—and an *object* being acted upon, for instance, in the case of surgery. Acknowledgement and empathy in Chapter 5 are ways of recognising others as not just a body, but a self. In Chapter 7, Finn, Hafferty and Quinton explore the role of

the body in HPE. The basic idea that the body is a subject and a Self but also an object and an Other has consequences for how discourses about sex, gender, science, race, ownership and many other issues relevant to HPE intersect with it. They argue, among other things, for "the critical engagement of health professionals and students with their own orientation towards their body" (129).

But how do we promote such critical engagement with not just the body but other social issues as well? How do we prevent the body—and other objects in HPE—being seen strictly as scientific objects, as Finn et al. warn against? Chapter 8 outlines Freire's philosophical view of how education can promote critical consciousness. Johnston, Hart and Manca argue that Freire's pedagogy may be used in HPE to transform it in a practice of freedom that flattens hierarchies, takes social and political contexts into account, and promotes reflexivity by, amongst other things, using stories as the center for teaching. This chapter itself can be used in dialogue with Chapters 3 and 6 to explore implications for subjectification and assessment.

But what are these social and political contexts that pose a threat to agency in the context of HPE? One of these threats is the lack of inclusivity of HPE: who has (more) agency? Dueñas, Politis and Danquah explore the concept of social justice from a students' perspective in Chapter 9. They do not only 'discuss' what critical consciousness in relation to issues of race, ethnicity, gender and widening access might mean for HPE, but also *demonstrate* it through analysing cases from their own experience while continuously reflecting on their own positionality with regard to these issues. Wånggren and Finn help us understand the "historical roots of gendered inequalities in health" (195) in Chapter 10. They point to how "modern biomedicine often comes to treat the patient as an object, infringing on the patient's agency over their health, this tendency has been critiqued especially by feminist health activists, who highlight the silencing of women's experiences in healthcare" (192).

In Chapter 11, Konopasky, Bunin and Varpio discuss another threat to agency, which they call *moral injury*. During medical training, trainees often find themselves in situations where they are obliged to act according to guidelines that are incongruent with their own values. What does it mean to exercise agency and maintain a sense of agency in these situations, and how can educators support them? In placing the concept of agency centre-stage and distinguishing between the exercise and the experience of agency, this chapter prepares the ground to go further down the rabbit-hole of this concept. In this and previous chapters, different philosophical perspectives have outlined the ambiguities and paradoxes of what is happening *to* me and *through* me, between myself and others as a subject and an object, as both a free agent and an identity operating in and constrained by a physical, social, and political context. Taking a further step, we might ask—who decides what is 'objective' and what is 'subjective'? Who decides where the boundary lies and what the relationship is between an 'agent' and the 'external world'? Chapter 12 discusses *ontology*, the branch of philosophy that is "the science of what is and the claims we can make about the nature of being and existence" (222). Though this is perhaps the most abstract type of philosophical inquiry, Wyatt, Ajjawi and Veen argue that to address some of the issues that have been discussed so far, it is not only desirable but indispensable that HPE professionals ask ontological questions. Since issues like educational value,

social justice, professional identity development and assessment depend on how we categorise and conceptualise the world we live in, and since the kind of assumptions we make about the world are not obvious but always emerge from our freedom in ambiguity, we are *responsible* for doing ontology. Doing ontology, as outlined in this chapter, can create space for "trainees and physicians to bring their whole selves to the profession" (234).

The subsequent two chapters discuss the main claimant to deciding on ontological questions in HPE: *science*. In Chapter 13, Kehoe, Rothwell and Bluhm challenge the view that the natural sciences should serve as the model for HPE. They offer a basic introduction to philosophy of science within HPE, which can serve not just to examine HPE and HPE research, but also the teaching of science within HPE curricula. In this way, they enable HPE professionals to assert agency by being able to consider and take responsibility for their philosophical orientations, questioning the philosophical orientations that are handed over to them as 'obvious'.

Chapter 14 explores one consequence of taking different philosophical orientations to doing science in HPE. Crampton and Buckland consider the difference between taking an individualist and a holistic perspective on social science in relation to the relationship between individuals and teams. In HPE, we mostly operate in teams, but should these be considered as a social phenomenon (or 'agent') in themselves, or as nothing more than the sum of individual agents? They argue that not only is the answer to this question relevant for how we resolve practical matters of education, but that agency is a *criterion* for determining which social phenomena exist in (and thereby are consequential for) HPE.

The importance of ethical values for HPE was already clear from the chapters that dealt with social justice (Chapter 9), feminist theories of agency (Chapter 10), and the threat of moral injury to agency (Chapter 11). If the world HPE professionals and students operate in is inherently ambiguous (Chapter 4), assessment in HPE depends on philosophical assumptions (Chapter 6), and we cannot even depend on obvious facts such as 'the body' (Chapter 7) or 'science' (Chapters 13 and 14), what should be the guidelines for our actions? In Chapter 15, Pilkington provides a much-needed introduction to ethics in HPE. Instead of looking for clear guidelines for how to act, Pilkington argues, educators should not just teach professional norms, but employ ethical theories while embracing their philosophical complexity.

One such issue that calls for an ethical approach is the question of how HPE professionals and students should relate to the reality of climate change. In Chapter 16, Richie argues that climate change is indeed a pertinent ethical issue, because it goes to the heart of the dictum to "do no harm". But this chapter also agendises both the complexity and necessity of asserting agency in a domain where questions of clinical responsibility, bioethics, and social justice intersect. The way Richie argues that the global 'macro' question of climate change is intimately related to the 'micro' interactions in the consultation room and is therefore a responsibility of future health care practitioners, is an example of asking—and answering—ontological questions in HPE (see Chapter 12).

The question of climate change and green bioethics also calls attention to another issue in HPE that is often overlooked, but which goes to the heart of agency: technology. The current climate crisis that found its roots in the industrial revolution and our relationship to technology is an extreme example of what Chin-Yee outlines in Chapter 17. We are used to thinking of ourselves as *agents* in relation to technology, conceptualising technology as machines and tools that we manufacture and are in control of. Chin-Yee, however, discusses philosophers of technology that have been critical of the view that technology is a mere instrument that we are in control of. The question of technology is an increasingly urgent issue in HPE, and another threat to agency in addition to those outlined already, due to the rise of medical technology in health care. Is technology an agent? If so, how does it relate to our own agency? How is technology inscribed with values that may conflict with those that we subscribe to in HPE? Chin-Yee outlines a nuanced approach to these kinds of questions that succumb to neither technological solutionism nor technophobia.

Kelly, Dornan and Ruparell further take up the ambiguous relationship between technology and care in Chapter 18, identifying technology as "a prime suspect for the loss of care" (346) the latter of which was discussed in detail in Chapter 5. They propose that philosophy can act as a therapy to balance technology and care and transcend the instrumental ways of thinking that Chin-Yee discussed in the previous chapter.

We may associate technology in the context of HPE primarily with *medical technologies*, i.e., relating to the skills and knowledge that students are trained in during their education. But in Chapter 19, Mayat, Edwards and Guckian reflect on one particular form of technology that goes to the heart of a central concept that was discussed in the first few chapters of this book. They argue that the rapid rise of social media is changing what it means to belong to a community, particularly the *community of practice* that is central to Professional Identity Formation. How is Professional Identity Formation changing if my peers and role models during medical training are not just the ones that I happen to end up with in my clinical placement, but also—and perhaps more so—my social media 'friends' and the 'Medfluencers' I follow? This is truly a philosophical question, in the sense that we cannot yet answer it because social media is developing so rapidly that 'traditional' HPE research cannot keep up. It would be interesting to explore how the previous two chapters (Chapters 17 and 18) could offer ways to further develop the notion of *subjectification* in addition to Professional Identity Formation, in the ways suggested by Verwer and Van Braak in Chapter 3.

The chapters so far focus on different aspects of HPE, as well as different philosophical lenses through which important issues in HPE light up. The remaining chapters of the book explore different relationships between philosophies or philosophical concepts on the one hand, and HPE as a whole. The first of these, Chapter 20, introduces the concept of *phronesis* as a way to combine issues of agency, science and ethics in "practical wisdom". Plews-Ogan and Sharpe argue that *phronesis* is a much-needed addition to medical knowledge and technical skill.

In Chapter 21, Schaepkens and Coccia add a further dimension to the context in which agency lives: philosophy of *time*—perhaps the most difficult philosophical

topic besides technology. While in our everyday practice, time seems something that is just passing (too quickly) or that tends to get booked up (in our schedules), Schaepkens and Coccia argue that there are in fact two ways to relate to time. The first is *chronos*, which is the kind of time that can be "measured, scheduled and micromanaged" (389) and is discussed in time-management courses. The second is *kairos*, which relates to the moments that matter most for HPE, those that stand out from the unending stream of events and that have educational value. They suggest that, in true philosophical fashion, we take the ancient Greek word for 'school', *scholê* to conceptualize reflection in HPE not as yet another task or goal, but as time free from any tasks and goal-orientedness. In terms of agency, *scholê* is time in which we assert agency precisely by refraining from any action.

But how do we apply such a contemplative philosophy to HPE in practice? Stoicism is a holistic philosophical approach that is a popular answer to this question in contemporary medical practice, but it is often misrepresented. In Chapter 22, MacLellan, Brown, LeBon and Guha provide an introduction to Stoicism and how it can be practically applied in HPE. At the heart of Stoicism is a philosophy of agency, that takes—among other things—reflection on what is within the reach of our agency (or in our control) as a starting point for deciding between action and inaction.

The final two chapters of this book provide an in-depth exploration of what are perhaps the two most relevant concepts in relationship to agency in HPE, which are also at the heart of Stoicism and many of the other philosophical approaches outlined in this book: dignity and humility. In Chapter 23, Pilkington argues that an approach rooted in the concept of *dignity* can provide a practical and holistic approach to ethics for HPE. Dignity means deep respect for another's agency as well as one's own, and the concept is both broad and narrow enough to provide practical application—and guide practical wisdom or *phronesis*—while also promoting continuous reflection on our own philosophical perspective. The other concept, *humility*, is placed in historical context in Chapter 24. Michalec, Hafferty, Piemonte and Tilburt provide a thorough exploration of humility within the context of HPE and healthcare.

Humility brings together different threads in relation to *agency*. The agency of healthcare professionals should always be characterised by humility and respect for the dignity of others, because ultimately our ways of organising healthcare and HPE are only our best responses to an ever-changing and ambiguous world. From the philosophy of science, we know that we do not have one perfect system for gaining knowledge, and from the philosophy of technology we know that we are not in control. But from the philosophy of education, we can embrace humility from the knowledge that *another's agency*, that is, of the trainees, is both the central aspect and beyond control of HPE. Acknowledging others, embracing ambiguity, and taking responsibility for continuing to ask ontological questions all require humility. This is evidenced by the fact that painful issues that none of us wish to be part of HPE continue to exist despite our best efforts: social injustice, gender bias, and climate change, to name a few.

Hopefully, the chapters in this book make one humble for two reasons: because there are so many helpful philosophical perspectives and therefore so much left to learn; and because none of these perspectives have been able to offer a definite

answer or a once-and-for-all solution. Instead of even attempting to provide such an overarching perspective, we hope that this example of mapping *agency* through the chapters inspires the reader to do the same with the concept or object that interests them most. For instance, other themes that could be tracked throughout the book are the question of what constitutes meaningful education, how we relate the ethical aspects of health professions education to its medical-technical aspects, or in which ways we can stimulate reflection and critical thinking. But we would also like to acknowledge that we, the editors, have been limited by our own social, political, and philosophical positionality.

For one, we have focused almost exclusively on western philosophy, with an emphasis on continental philosophy. There is a whole world of 'non-western' philosophy left to explore. For instance, Buddhist and Taoist philosophy have much to offer in relation to the crisis of stress and burnout but can also address 'westernising' practices such as what we now call 'mindfulness' by reuniting them with their philosophical roots. Indigenous philosophies have much to offer to critically interrogate the way we conceptualise the relationship between individuals and communities, between ourselves and nature, and our relationship to our bodies. In addition to philosophical perspectives, we have also been unable to address some topics that are unquestionably relevant to HPE, for wont of space. Take mortality, which is perhaps most often cited in any philosophical school as the start of philosophy. Or burnout, stress, and reflection. And while we did include chapters about gender and social justice, LGBTQIA + -related issues deserve more attention. Finally, though we have attempted to include voices that are often marginalised in both HPE research and in philosophy, and are proud to have several authors who are, at the time of writing, students, or medical trainees themselves, in order to remain relevant for the future of HPE, a greater proportion of our authors should, perhaps, have been trainees.

With these limitations in mind, we would like, in closing, to focus on what might be the practical value of this volume, by looking at what the authors of all the chapters have listed as practice points. As we have indicated in the introduction, we make no claim to know what exactly philosophy 'is' and what its practical value for HPE could be. Instead, we have performed a kind of experiment in which we invited a range of experts in HPE and philosophy to apply one philosophical perspective to one pertinent issue in HPE and close their chapter with five practice points.

25.1 Our Practice Points

Each chapter in this book offers practice points based on the discussion of some key topic through a philosophical lens. We requested five practice points per chapter from the authors to do justice to both the richness of philosophical perspectives that cannot simply be summarized in one 'call to action', while also giving concrete starting points to apply the subject matter in practice. It is important to note that there are many more possible practice points for each chapter. The points each author or

team of authors have provided are simply a starting point in applying the discussions of this book to your own practice.

There are insights that span several chapters' practice points. If you have chosen to read this book cover-to-cover, you might have noticed that chapters on very different topics, that approach these topics in very different ways, sometimes make similar recommendations. This is interesting—despite diversity in perspective and approach, there are some applications for practice that more than one philosophical approach recommends. You may have your own thoughts on what these common themes are—we offer ours, what we have noticed as threads which weave the tapestry of this book's practice points together into a cohesive whole.

First, we note that many chapters encourage their readers to engage in a process of critical reflection. Some also encourage readers to prompt their students and colleagues to reflect. These sorts of reflection involve considering one's own perspective, experiences, or practice as a starting point for engaging with a new way of thinking about a contemporary or side-lined topic in health professions education. In Chapter 21, Schaepkens and Coccia consider the nature and practice of reflection, a popular topic and practice, in our field. They argue that, in addition to goal-orientated reflection (which, for example, might include reflecting on how you communicated with a specific patient or colleague in your practice today), reflection without preconceived goals is also valuable. As the chapters in this book prompt you to reflect, we encourage you to reflect broadly, to give yourself the time and space to question the taken-for-granted practices and ideas in our field. Think beyond reflecting only on your own practice—what you do well, how you might improve—and consider how the philosophical insights offered by each chapter might question the "unquestioned heritage" (Schaepkens and Coccia 2022, 389) of our field.

Implicit in this commonality between practice points is an understanding that philosophy can help us excavate, and then interrogate, the assumptions that we make as we educate and research as health professions scholars. Chapter 13, which offers an overview of the Philosophy of Science is an example of what asking such difficult questions might look like in practice. Before I set out designing a health professions education research project, I must consider my understanding of the nature of reality (ontology), and of knowledge (epistemology). I should also examine how the question I wish to ask, and so what I do to try to answer (at least in part) this question, align with these understandings, to ensure robust research design. These can be difficult practices to engage in—our field is steeped in a 'natural sciences' tradition, where quantitative empirical research reigns supreme, and authors often approach research questions best suited to different ontologies and epistemologies through a positivist lens, which impacts the quality of the research we produce. Considering Philosophy of Science, as Chapter 13 does, helps pick apart these sorts of considerations, guiding us in asking these difficult questions of ourselves and our practice.

Also relevant to our 'unquestioned heritage' is the call many chapters make for an increased awareness of the *context* in which we practice. Chin-Yee in Chapter 17 draws our attention to the fact that technology is not value-neutral. How artificial intelligence operates in our field is shaped by context—by humans who are socialised and politicised creatures at work in specific cultures. We would extrapolate this

insight—nothing we do is value-neutral. Our actions—the way we design educational programmes, our assessment practices, how we engage with students—are shaped by social, political, cultural, and economic forces. Without examining this context, we risk contributing actively to the marginalisation of certain groups, rather than advocating against discriminatory practices. Chapters 4, 8, and 9 all highlight the importance of focusing on freedom—for example, freedom for patients—as a driving goal of healthcare. As educators and practitioners, this means we must critically evaluate the way in which our pedagogy works (or doesn't) towards challenging oppression and promoting justice for the patients healthcare serves.

You might be thinking that this sounds challenging. We would be lying if we said it was not. Institutional support is key to enabling the more radical pedagogical change some chapters suggest (such as the call for climate change modules made by Chapter 16, or the call for longitudinal education made by Chapter 20). Whilst we encourage educators to engage with these calls and advocate for such changes within their own institutions, we do acknowledge that in some settings educators may feel they are fighting an uphill battle. Making small changes to their own practice might help educators keep faith whilst rallying against institutional barriers. In Chapter 8, Johnston et al. offer examples of such small changes educators can make to their own practice to facilitate dialogic learning and so contribute to critical consciousness-raising. Through something as simple as taking charge of the furniture in one's educational space, educators can facilitate the transition of health professions education from a 'banking' model to a 'problem-posing' approach that allows students to develop a sense of criticality. Both small-scale and large-scale changes within our field are likely necessary in realising the vision of this book—in acting on the beginnings of an applied philosophy for health professions education that we have set out.

As a starting point for realizing both small-scale and large-scale changes, we might close with a final recurring theme in the practice points. Instead of looking at HPE as a collection of entities, we might look at it as being composed of *relationships*. This includes human relationships, but also relationships to technology, and to forms of knowledge, such as about assessment. Many chapters ask us to focus on important aspects of HPE, such as the quality of education, the need for assessment, or the patient's body, but without losing sight of the fundamental human relationships that are at the heart of HPE. For instance, we must trust students' capability to form themselves (Chapter 2) but can use narratives—which are all about relationships—in teaching (Chapter 8), and engage in positive role modelling, coaching, and mentoring to stimulate practical wisdom (Chapter 20). Other chapters point out relationships that have been neglected, such as between the body and gender (Chapter 7). It seems that many chapters are a call to focus—or re-focus—on the essence of that aspect of HPE. In doing so, we focus on what truly matters, and allow that to inform both our teaching and our conversations about change.