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

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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

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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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