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Medical Education for Social Justice: Paulo Freire Revisited

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Abstract Although social justice is an integral component of medical professionalism, there is little discussion in medical education about how to teach it to future physicians. Using adult learning theory and the work of Brazilian educator Paulo Freire, medical educators can teach a socially-conscious professionalism through educational content and teaching strategies. Such teaching can model non-hierarchical relationships to learners, which can translate to their clinical interactions with patients. Freirian teaching can additionally foster professionalism in both teachers and learners by ensuring that they are involved citizens in their local, national and international communities.

Keywords Professionalism · Social justice · Medical education

Introduction: Social justice and medical professionalism

In 1848, Rudolf Virchow, considered the father of social medicine, wrote: "Medicine is a social science, and politics nothing but medicine on a grand scale."[1] Despite this greater than century old declaration, however, the relationship of the profession to social issues has been, at best, inconsistent. For instance, one need only look at the AIDS pandemic to realize how medicine struggles to recognize the relationship of social inequalities to health.[2] Yet, there appears to be a growing concern among medical educators regarding the teaching of social issues to trainees, and current discussions around medical professionalism have begun to incorporate social justice as integral to the education of future physicians.

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[1] As quoted in Anderson, Smith and Sidel.

[2] Anderson et al., "What is Social Medicine?" 56–58.

In the context of increasing economic and political stressors on the health care professions, medical educators have become especially concerned with defining the ideal practices of the profession. Organizations such as the American Board of Internal Medicine and the American Association of Medical Colleges have become involved in discussions around professionalism, and definitions of the concept often incorporate physicians' social responsibilities as well as their behaviors with individual patients. Behaviors manifesting professionalism include, among other things, a subordination of physicians' interests to those of their patients, adherence to high ethical and moral standards, and a response to societal needs.[3] One recent document, the Charter on Medical Professionalism, defines the three fundamental values of medical professionalism as the principle of primacy of patient welfare, the principle of patient autonomy, and the principle of social justice. According to this document, physicians practicing professionalism are expected to "promote justice in the health care system, including the fair distribution of health care resources." In addition, "physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category."[4]

Although social justice is a key component of medical professionalism, is it practically enacted? Is social and individual responsibility to patients being taught in medical curricula? The culture of medicine as described by both students and faculty indicates otherwise. Although progressive organizations, including Physicians for Reproductive Health and Choice; Medical Students for Choice; Physicians for Human Rights; Physicians Against Nuclear War; and Physicians for Social Responsibility exist, these organizations are, at best, marginal in health care culture and certainly, in medical training.[5] The "hidden" or informal curriculum of medicine remains one that not only teaches students to value hierarchy but also to refrain from social or institutional critique.[6] A recent collection of writing, ***What I Learned in Medical School,*** chronicles the struggles of diverse students, including women; lesbian, bisexual and gay students; students of color; economically disadvantaged students; and disabled students into "arguably the most restricted, traditional, and powerful educational institution ever established in America."[7] In this collection, medical student Karen C. Kim, a self-described "small fry in the world of radicalism," describes being labeled a "revolutionary," "social activist" and "communist" for her concern about disparities in health care, racism in medicine, and reforms in the medical system. She writes: "What is ... disturbing ... is precisely how little politicization and social consciousness it takes for someone in the medical field (even a student) to fall outside the professional mainstream."[8]

Similarly, physician educators find very little space in mainstream medicine to critique openly the establishment or follow the goals of social justice. Medical educator, Delese Wear, writes: "I have often thought that medical education and feminism seem incompatible: a woman cannot be affiliated or identify with both (simultaneously)... because one is a job description with rules, norms, and boundaries for acceptable beliefs and behaviors, and the

[3] Swick, "Toward a Normative Definition of Medical Professionalism," 612–616.

[4] "Medical Professionalism in the New Millennium: A Physician Charter," 243–246.

[5] Joffe et al., "Uneasy Allies: Pro-Choice Physicians, Feminist Activists and the Struggle for Abortion Rights," 775–796.

[6] Hafferty et al., "Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum," 403–407.

[7] Kim et al., *What I Learned in Medical School: Personal Stories of Young Doctors,* xvii.

[8] Kim, 75–79.

other a political project often working at oppositional angles to those very practices, she may be inclined to regulate her feminism – or have it regulated for her."[9]

The question that emerges is how to operationalize the lofty educational goals of social justice and professionalism. The current culture of medicine does not incorporate social issues as central to its practice; moreover, when such a perspective is incorporated into medical education or residency training, issues including health care disparities, culturally and linguistically accessible care, homelessness, poverty and immigration are usually afforded a one-hour lecture block at the end of a long day of physiology and pathology or situated in the middle of rigorous hospital-based clinical responsibilities. This not only reinforces a perception of social justice issues as an "add-on" to the central curriculum but also fails to engage trainees in effective ways. If social justice is an integral part of teaching young physicians the tenets of professionalism, how do we as medical educators construct a pedagogy for social justice that is far reaching, consistent and central to our educational endeavors?

The authors of this essay were drawn to medicine because of a desire to work toward these very goals—a desire to address social inequities and serve underserved patients. Our vision of medicine is as a practice for social change. As educators, our work with students and residents has challenged us to translate these values into our teaching. In meetings for two fellowship programs in the Bronx, faculty and fellows address issues of faculty development, education and women's reproductive health. Such discussions have facilitated our thinking not only about the important role of social justice in our professional practice but also about the methodologies by which to teach it. In addition, our affiliation with the residency programs in social medicine at our institution has allowed us to experience challenges and successes in the incorporation of social justice work into postgraduate medical education.

Paulo Freire and a new philosophy of education

Teaching social justice to support professionalism demands a new look at medical pedagogical styles. The authors turn to Paulo Freire, the Brazilian educator whom Cornel West has called the "exemplary organic intellectual of our time."[10] In basing this discussion on some of Freire's revolutionary educational concepts, we admittedly run the risk of "domesticating" him, simplifying and depoliticizing his work.[11] However, although Freire's work has been "reinvented and applied"[12] in many North American academic settings, there has been little introduction of his ideas into medicine, beyond community-based health education.[13,14] In our discussion of social justice in medical education, we revisit Paolo Freire's work in three frameworks: educational methodology, clinical care and the broader social context.

Educational methodology

Social justice issues have been acknowledged, at least marginally, in medical education content. However, in order to teach for social responsibility in medical practice, we as

[9] Wear, *Women in Medical Education: An Anthology of Experience*, ix.

[10] Freire, *Paulo Freire: A Critical Encounter,* xiii–xiv.

[11] Aranowitz, *Paulo Freire: A Critical Encounter,* 1–7.

[12] Freire, *Paulo Freire: A Critical Encounter,* ix–xii.

[13] Van Wyk, "Health Education as Education of the Oppressed," 29–34.

[14] Fahrenfort, "Patient Emancipation by Health Education: An Impossible Goal?" 25–37.

educators not only have to rethink what we teach but also, more fundamentally, how we teach it. According to Freire, education has the potential to be liberating or domesticating, a process of empowerment or learned intellectual and social passivity. In the words of educator, Ira Shor: "Education is not reducible to a mechanical method of instruction. Learning is not a quantity of information to be memorized or a package of skills to be transferred to students . . . a Freirean class invites students to think critically about subject matter, doctrines, the learning process itself, and their society."[15] In this framework, it becomes absurd to teach social justice as a subject matter, a skill set or knowledge base; rather, by teaching all relevant subjects, including social issues, in a new way, social justice becomes an integral part of the process of education itself.

Although there have been some changes, medical school and clinical training programs are still generally consistent with what Freire would call the "banking model of education," whereby teachers "open students' heads to the treasures of civilized knowledge."[16] In "banking" type classrooms, Freire argues: "Education becomes an act of depositing . . . deposits which the students patiently receive, memorize and repeat . . . knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing."[17] Indeed, medical knowledge is often framed as a "gift," an honor-bound tradition handed down from experienced clinicians to inexperienced trainees. In the clinical setting, learners are repetitively reminded of their powerlessness through rituals such as "pimping"—Socratic questioning on clinical rounds – and expected to undergo ritualistic humiliations including the subservience of their own bodily and personal needs to the higher goal of clinical learning. Such practices only reinforce the notion that the learner is less important than the knowledge learned.

However, medical education has made some strides toward changing the traditional banking model. Some educators have turned to adult learning theory, which incorporates principles such as learner autonomy, problem-centered learning, incorporation of learners' past experience, and reinforcement of practical applications of the lessons taught[18] as an alternative to traditional teaching in medicine. Freire's notions of problem-posing and co-intentionality can be applied to further inform this model and inspire us as medical teachers. Shor writes: "A Freirean critical teacher is a problem-poser who asks thought provoking questions and who encourages students to ask their own questions. Through problem-posing, students learn to question answers rather than merely to answer questions. In this pedagogy, students experience education as something they do, not as something done to them."[19] Problem-posing creates the potential for teacher and students to develop "co-intentionality," that is, mutual intentions whereby the knowledge sought is mutually owned rather than the sole property of the educator. This style of teaching has the potential to transform both the educational endeavor and the relationship between teacher and learner.

Problem-posing is more than a methodology, it is a theoretical foundation for educators. It is related to, but not the same as problem-based learning, an approach began at McMaster University in the mid-1970's and adopted in various forms at many North American medical institutions. It is not our contention here that all medical education should be done in a case-based or PBL-style format. Rather, if we adopt a problem-posing approach from Freire,

[15] Shor, *Paulo Freire: A Critical Encounter,* 25–35.

[16] Aranowitz, 9.

[17] Freire, *Pedagogy of the Oppressed*, 72.

[18] Merriam and Caffarella, *Learning in Adulthood: A Comprehensive Guide*.

[19] Shor, 26.

educators working in any sort of learning framework are challenged to de-privilege their own power and authority and become informed, experienced and knowledgeable facilitators of student learning rather than the "depositors" of information into the mental "vaults" of learners.

While we are not suggesting that we as educators abandon the notion that we may have valuable experience and expertise to share with our trainees, we are suggesting that in order to teach our students a socially conscious professionalism, we have to be critically conscious of our power as teachers. This may be as simple as role modeling the ability to say, "I don't know," and consulting a textbook along with a trainee – or along with a trainee and a patient. It may mean abandoning a carefully constructed Power Point lecture and eliciting the needs of a roomful of learners. It may mean allowing residents to have real input in curricular matters – constructing and conducting educational endeavors when appropriate. What we are suggesting is more than teaching social issues or even the skills of social advocacy. By empowering our students and facilitating an environment in which they can think critically about medical issues, as well as medicine as a profession, we create future physicians who are empowered to think critically about social issues in general.

Clinical care

Medical education is different than many other forms of education in that our teaching is both classroom and practice-based. Trainees function essentially as apprentices in the clinical setting, and educators model for them appropriate patient care. However, medical training is also "one component in a series of interlocking relationships"[20]–a parallel process. In other words, the way in which educators interact with students and residents models the way in which trainees then interact with patients. Freire's lessons are applicable in both classroom and clinic, as the physician-patient dyad is not only one of clinical care but also and oftentimes primarily, one of patient education. For this reason, patients (in the case of pediatrics, patients' families) can be seen as adult learners by trainees who can practice a care modeled on their own educational relationships with problem-posing teachers.

Creating a non-hierarchical learning environment in which trainees are encouraged to critique, question and challenge teachers models for trainees the creation of a similar clinical environment, where patients are encouraged to raise questions and speak frankly to their doctors about their concerns. Similarly, mutually agreeing to short-term learning goals with a preceptee in clinic, such as being able to distinguish pathologic from nonpathologic murmurs, rather than the preceptor deciding that the learner should accurately interpret an EKG, models for that learner the creation of mutually agreeable short-term goals with patients, such as the ability to walk up to one's apartment without wheezing. Moving away from a "banking" model of education not only enables students to be empowered in their own education but also to become better clinicians who enable patients to be empowered in their own health.

Social context

Ultimately, a Freirian pedagogy would create classrooms and clinics in which "educators pose critical problems to students, treat them as complicated, substantial human beings, and

[20] Shapiro, "Parallel Process in the Family Medicine System: Issues and Challenges for Resident Training," 312–319.

encourage curiosity and activism about knowledge and the world."[21] Questioning, critiquing and discovering knowledge in the classroom fosters these same behaviors in the clinical world and can ultimately lead to analysis of the broader social environment as well as advocacy for social change. The challenge for teachers is to "create critical thinkers who will find their place in society" through "an education of and for citizenship."[22] In other words, we must train physicians who not only uphold a high ethical and moral standard of individual practice but also operate as invested citizens of their varied local, national and international communities. This would exemplify the ultimate measure of professionalism.

Educators have the opportunity to frame both classroom and clinical education in a new way and facilitate learning experiences outside of traditional settings. The authors of this essay work in an institution with three social medicine residency programs, which incorporate a commitment to clinical service in underserved communities and a philosophy of activism and social justice. Residents volunteer clinical time, work in conjunction with community-based organizations, and have no inpatient responsibilities during specific months when they are expected to conduct community-based research and/or program development – "social medicine" projects. Examples of recent "social medicine" projects conducted by our residents include interviews of local Bronx residents about the presidential election in conjunction with a voter registration drive in the clinic and the creation of a school-based exercise and nutrition program at a local elementary school.

However, educating for social citizenship can occur even without structural benefits such as time for such projects. Similar to educators at many other inner city institutions, our precepting on obesity often highlights the inequities of food distribution, including the quality and the price of fresh fruits and vegetables. However, what has been even more effective has been sending trainees into the local community to nearby supermarkets or local donut shops. The experience is a visceral one, as trainees see firsthand that the price of fried or heavily processed foods is often significantly less than healthier alternatives. Similarly, a recent "lecture" on emergency contraception (EC) for interns was transformed into a hands-on experience in which trainees telephoned and visited local pharmacies and clinics in search of emergency contraception. Placing trainees in the position of patients allowed them to experience the incredible difficulties and prejudices faced when trying to obtain EC. The interns themselves concluded that they should both offer advance prescriptions of EC to their patients and assume the responsibility of teaching their colleagues and clinic preceptors about EC.

Conclusion

If "professionalism is the basis of medicine's contract with society,"[23] we as educators must grapple with the challenge of effectively bringing social responsibility into our medical teaching. Such change in medical education is not only an issue of content but also of methodology. Revisiting educational thinker Paulo Freire can help medical educators reframe the traditional hierarchical patterns of medical learning which too often translate into paternalistic medical care at odds with the stated ideals of medical professionalism. Teaching with a Freirian vision means openly addressing power discrepancies while valuing

[21] Shor, 26.

[22] Freire, *Teachers as Cultural Workers – Letters to Those Who Dare Teach,* 90.

[23] "Medical Professionalism in the New Millennium," 243–246.

and respecting the input of both teacher and learner. De-privileging our own authority as educators can contribute to real cultural change in our profession, modeling non-hierarchical and respectful relationships that trainees can then translate into their clinical care. In this way, ideals of social justice can be operationalized for both learners and teachers toward broader goals of social critique and change.

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