Physicians in Philosophy of Education: From Cameo Appearance to Leading Role

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Introduction

Philosophers of education commonly note that they are interested not only in K–12 schooling but in education conceived more broadly, including adult education, higher education, and informal learning. In higher education, some disciplines and fields have developed systematic inquiry into their own educational practice. The health professions — including, for example, medicine, nursing, and physical therapy — are cases in point, with professional associations, journals, research centers, and degree programs focused specifically on health professions education. In the philosophy of education literature, parallels have been drawn between nursing and teaching as "interpersonal" or "service" professions[1] and some philosophers of education have established productive connections with nursing; for example, Nel Noddings's work on caring is used widely in nursing education, and Paul Standish is co-editor of the volume *Philosophy of Nurse Education*.[2] However, in the area of medical education, that is, the education and training of physicians and surgeons, the connections have thus far been thinner.

I came to this realization during a stint as "philosopher in residence" at a research center focused on health professions education. In talking with medical education scholars, familiarizing myself with medical education literature, and re-reading philosophy of education literature for what it might say about medical education, it struck me that there were many potential, but few actual, conversations between the fields of medical education and philosophy of education. When philosophers of education have made reference to physicians and surgeons, it has often been by way of comparison with teachers. Many colleagues have found it useful, in order to gain greater clarity about the practice and profession of teaching, to examine its similarities to and differences from medical practices and professions. Few philosophers of education, however, have considered the specificity of medical education as a subset of education. Rather than comparing teachers and doctors, what might philosophers have to say about the teaching *of* doctors?

In this essay I first provide two examples of the ways in which philosophers of education have referred to medical practices and professions. I contrast this with the work of some philosophers of education who have begun to address medical education specifically. I then give some other examples of concepts and practices in medical education that are worth the more sustained attention of philosophers of education, including the idea that physicians should be health advocates, and the conceptual and normative questions this idea raises. The purpose of these examples is to illustrate the argument that medical education and philosophy of education would both benefit from a more sustained engagement with each other.

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Cameo Appearances of Physicians in Philosophy of Education

In an analysis of the role and relevance of educational theory for the practice of teachers, David Carr makes an extensive comparison with the role and relevance of theory for the practice of surgeons.[3] In the course of his analysis, Carr considers the "competence conception of occupational expertise," which sees occupational expertise as consisting in rational skills and practical reason, without requiring explicit theories or theoretical reason. However, while this conception may be sensible for certain trades, such as hairdressing, Carr rejects it for the "higher professions":

> For example, while a surgeon may not be consciously applying a theory when he excises that tumour, he is nevertheless utilising a technique which presupposes a good deal of scientific knowledge of the human body; in short, the practical skills of a competent surgeon are by no means independent of theory since they represent the essentially technological application to practice of scientific knowledge which could not possibly be had independently of an intelligent grasp of theoretical research and enquiry.[4]

In its dependence on theory, surgery — a practice involving specific practical skills — is different from other practices involving specific practical skills, such as hairdressing. Carr argues that while teaching involves more theory than hairdressing, there are nevertheless significant differences between teaching and surgery in the relation between theory and practice: "One way to put this is to observe that it would be considerably less alarming to encounter a practising classroom teacher who had never heard of Piaget, Bernstein or Stenhouse than it would be to discover a practising surgeon who had little or no knowledge of anatomy or physiology."[5] The reason this is so, according to Carr, is that "effective surgery depends on a thorough knowledge of anatomy or physiology" while, supposedly, effective teaching does not, or not to the same extent, depend on a thorough knowledge of developmental psychology, sociology of education, or curriculum theory.[6]

Carr appears to appeal to a commonsense understanding of surgery as a technically difficult and high-stakes practice and teaching as a technically less difficult and lower-stakes practice, but he does not actually consider that a cardiac surgeon may do just as well without remembering the anatomy of the foot as a high school English teacher may fare without remembering early childhood developmental psychology. Moreover, the relation of anatomy to surgery is of a different nature than the relation of sociology of education to teaching; it would be fairer to ask whether good surgery is more, less, or equally dependent on the surgeon having been taught sociology of health than good teaching is on a teacher having been taught sociology of education. Carr continues:

> The trainee surgeon is unlikely to experience difficulties in understanding the relevance to his training of lectures on anatomy and physiology of quite the same sort as those of which trainee teachers frequently complain with regard to their lectures on sociology or psychology. In medical school teachers of theory and teachers of techniques can pursue their diverse enquiries with reasonable confidence that their separate contributions ultimately conduce to a common goal of health promotion, whereas the theories which trainee teachers are taught so often appear to them to be remote from, out of touch with, even irrelevant to, the real-life business of classroom teaching.[7]

This passage makes it even clearer that the surgeon is not a well-developed character in Carr's story. If Carr considered surgeons and their education with the

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same attention as he did teachers and their education, he would realize quickly that medical students take all sorts of classes that will not end up being relevant to their particular surgical or non-surgical specialty. More importantly, just as being a teacher involves significantly more than engaging in the "real-life business of classroom teaching," being a surgeon involves significantly more than engaging in the real-life business of surgery in an operating room. The examples later in this essay of the different roles expected of physicians in addition to their clinical role will hopefully clarify this.

Carr proposes an Aristotelian way of understanding teachers, but does not relate this proposal back to the surgeons that appeared earlier in his argument. It turns out surgeons were simply a placeholder for a complex and well-respected profession, one that stands in obvious contrast to a trade such as plumbing or hairdressing, and he might just as well have used another technically difficult and high-stakes profession, such as airline pilots. Carr does not, for example, consider to what extent the Aristotelian approach and the distinction between *phronesis*, *techne*, and *theoria* would be a useful framework to think about the education and training of surgeons.

A second example of a philosopher of education who makes reference to physicians as a comparison with teachers is Nel Noddings, who takes issue with Alisdair Macintyre's argument that teaching is not a practice, while medicine is.[8] She draws from Israel Scheffler's argument that for an activity to be called "teaching," it must meet the criteria of intention, reasonableness, and manner. In her discussion of the criterion of manner, Noddings writes:

> The teacher as person is centrally important in teaching. A physician can concentrate entirely on treating her patients; so long as she exercises the virtues that reflect her expertise, her personal character and personality matter very little. But the teacher sets an example with her whole self — her intellect, her responsiveness, her humour, her curiosity … her care.[9]

The contrast suggested here between teachers and doctors lacks important nuance. The extent to, and way in which a teacher's character and personality matter to teaching will vary considerably with the type and context of teaching. For a kindergarten teacher, who spends much of her time socializing children, character and personality will be more central to the work of teaching than for a university lecturer in statistics, whose main challenge will be to explain statistics as clearly and precisely as possible to a large lecture theatre of undergraduate students. Noddings may have intended to make the point that the character and personality of a teacher always matter in some way and in some degree, but of course this is no different from doctors, for whom character and personality always matter in some way and in some degree. A gynecologic oncologist certainly must be able to concentrate on treating her patients, and diagnostic knowledge and surgical skills will matter greatly, but her personality and character are not unimportant, as she needs, for example, to be able to discuss treatment options with patients and their families. For a generalist such as a family doctor the idea that "personality and character matter very little" is even stranger, as the relation between a patient and a family doctor often lasts years and the personality and character of the doctor play a role in the establishment of trust in that relation.

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Leading Roles for Physicians in Philosophy of Education

In recent years, a few philosophers of education have addressed medical education in its specificity. One of them is Ruth Cigman, who, based on her experience teaching ethics in a medical school in the United Kingdom, charges that "medical ethics" is typically taught as "checklist ethics," that is, a way of arriving at a right answer that will keep doctors out of trouble with the law or their professional college.[10] She contrasts the typical clinical way of presenting a case history to medical students — a bulleted lists of basic facts — with a thick description of a patient and her or his interaction with a physician. The latter tends to provoke doubt and hesitation about the "right answer," which is where medical students' ethical thinking in a deeper sense can begin: "There is a gap between their easy command of principles like respect for autonomy and their ability to understand what is really going on in an encounter between two human beings."[11] While Cigman presents her argument as one of a positive-versus-negative conception of ethics rather than as an argument about education, her argument addresses important questions of how professional ethics can and should be taught in medical schools, and of how the pedagogical and curricular choices in professional ethics courses for medical students speak to underlying conceptions of what makes a good doctor.

Christopher Martin uses philosophical perspectives to address the idea of physician-as-communicator, one of seven roles identified by the Royal College of Physicians and Surgeons of Canada in the *CanMEDS Physician Competency Framework*.[12] Martin argues that Jürgen Habermas's theory of communicative action would be a robust way to think about physician communication as not a technical-instrumental competency — skills that facilitate, say, the achievement of a more accurate diagnosis, or better patient compliance with a recommended treatment — but rather as a "medical-epistemic competency."[13] The competency is "medical" because the abilities required for communicating well with patients and colleagues are specific to the practice of medicine; the competency is "epistemic" because at the heart of Habermasian communication is the developing of "an understanding of the interests and needs of others."[14] Moreover, thinking of communication as medical-epistemic competency also encourages physicians to see communication as grounded in a broader set of values or "communicative ethics." An educational question raised by this reconceptualization of medical communicative competency is, of course, how such a competency can best be taught and learned. Martin argues that medical students should "have an opportunity to develop an understanding of how principles of communication are constitutive of human interaction," which "means that such principles ought to be modeled in teacher-student interaction."[15]

Elsewhere Martin argues that medical education, which is subject to critical reassessment and reform in many countries, would do well to revisit the philosophical tenets of one of its founding documents, Abraham Flexner's 1910 *Medical Education in the United States and Canada*. Flexner saw clearly that the educational question was not so much how to train physicians well, but rather "What does it mean to be an educated person *who is also a doctor*?"[16] Martin suggests that scholarship

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on liberal education and, in particular, Michael Oakeshott's view of education as initiation into a tradition, would enable a more philosophical discussion about the direction of medical education reform: "What are the historic achievements of medicine and, given such achievements, what then does it mean to say that one is an educated doctor?"[17] It seems to be somewhat overlooked today that this question was central also to Flexner's views on medical education.

Competency, Advocacy, and Other Promising Roles in Philosophy of Medical Education

The above — and all very recent — examples show that some philosophers of education are beginning to examine and contribute to medical education. However, medical education is a large field, and many more of its theories, practices, and policies are ripe for philosophical inquiry. As an example, I will explore here some recent work in the medical education literature on the role of health advocate, and the fruitful conversations with philosophy of education literature this work could broach.

As mentioned earlier, medical boards in the United States and Canada expect physicians to develop and maintain not only their clinical skills but also other abilities such as communication with patients and collaboration in interprofessional teams. In Canada, one of the roles expected of physicians is that of health advocate. Sarah Dobson, Stéphane Voyer, and Glenn Regehr observe that this role has been "a source of puzzlement and contention" and argue that this has much to do with a lack of clarity in the idea of advocacy and in the way it has been elaborated in the CanMEDS framework.[18] The authors make a good start with a conceptual analysis of the term "health advocate" and the way it is elaborated in the CanMEDS framework, arguing that it unhelpfully collapses activities that advance the health and wellbeing of individual patients, and activities that advance the health and wellbeing of communities and populations. Putting it differently, the role of health advocate combines the role of *agent*, that is, someone who "works the system" on behalf of an individual patient, with the role of *activist*, that is, someone who seeks to change the system on behalf of a group of patients or a community. Unsurprisingly, the idea that physicians should act as (ethical) agents on behalf of individual patients is much less controversial than the idea that physicians should act as (political) activists on behalf of a group of patients or a community. Dobson, Voyer and Regehr argue that distinguishing the agent from the activist role allows for specific questions about the latter, such as whether this role is one that every physician is responsible for adopting, or whether it is one that the profession as a whole, or perhaps designated members of the profession, should take on.

The analysis raises at least two further issues the authors do not (yet) explore. The first is that there is in medical education a strong focus on assessment of the competencies outlined by the professional body. The discussion often focuses on what competencies physicians should be expected to have, and how patients and the public at large can best be assured they have them. Great efforts are made to ensure the various instruments that test medical students' competencies are as reliable and valid as possible, but less attention is paid to the pedagogical models by which said

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competencies are best taught. How does one teach someone to be a "health advocate"? What would be the value of experiential learning, the encounter with a patient or community in need of advocacy, as compared with direct instruction and mentorship? To what extent does teaching someone to be a health advocate involve the instruction or modeling of skills, and to what extent does it involve the cultivation of an attitude?

This brings me to the second issue: the concept of "competency," and the question of whether agency, activism, and advocacy are properly described as competencies. The medical education literature and philosophy of education literature have separately analyzed and critiqued the concepts of competence and competency. For example, rhetorician and medical education scholar Lorelei Lingard proposes that the idea of competence in health professions education functions as "god term," an unquestionable idol on which pedagogical, curricular, and assessment decisions hinge.[19] And philosophers of education Donna Kerr and Jonas Soltis argue that teaching competencies must take into account the multiple actions (rather than behaviors) that comprise teaching, and involve not only discrete skills and performances but "a teacher's interpretations, choices, reasons, and judgments" in these various actions.[20] When it comes to the understanding of physician roles such as "professional," "collaborator," or "health advocate" as consisting of different competencies, and such competencies as both assessable and educable, a more sustained conversation between philosophers of education and medical education scholars would be productive.

The 2005 version of the CanMEDS framework states: "Physicians possess a defined body of knowledge, clinical skills, procedural skills and professional attitudes, which are directed to effective patient-centered care. They apply these competencies to collect and interpret information, make appropriate clinical decisions, and carry out diagnostic and therapeutic interventions."[21] In other words, the concept of competency is introduced as encompassing not only clinical and procedural skills, but also knowledge and professional attitudes. However, in the list of "key competencies" and "enabling competencies" under the role of health advocate, the attitudinal aspect of this role is not elaborated. The competencies are all described with the behavioral verbs that are expected in a competency model; within the health advocate role, physicians are expected to be able to "respond," "identify," "promote," "describe," and "appreciate" (although it is left unspecified how "appreciation" should be demonstrated).

Further work can be done to specify what professional attitude is required for someone to be an effective health advocate, but that health advocacy has an attitudinal component is obvious. A parallel can be drawn here to educational scholarship on critical thinking, where even those who have argued that critical thinking skills are fairly generic and transferable have also emphasized the need for such skills to be accompanied by a disposition to use these skills: "a critical thinker must not only be able to assess reasons properly, in accordance with the reason assessment component, she must be disposed to do so as well."[22] In the case of health advocacy, skills are a necessary but not sufficient condition for an effective uptake

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of the role. A physician may be able to "identify the determinants of health of the populations [they serve], including barriers to access to care and resources" and to "describe the role of the medical profession in advocating collectively for health and patient safety,"[23] but if the physician is not inclined to use these abilities and act upon them, it seems to me that he or she cannot be considered a "health advocate."

While attitudinal components of health advocacy are not spelled out among the competencies to be assessed, in practice, those who teach medical students and residents do understand that attitudinal components matter. In a study of written qualitative comments made by faculty supervisors of internal medicine residents, Shiphra Ginsburg et al. found that "faculty frequently comment not just on competency-related factors but also on 'noncompetency' domains" such as the resident's attitude and personality.[24] Although, as I showed above, the CanMEDS framework mentions attitudes among other competencies, Ginsburg et al. are adamant that attitude and personality — which they group together under the theme of "disposition" — are "not competencies at all."[25]

If one wanted to assess whether someone, in addition to the skills required for advocacy, has the dispositions of advocacy, one could further ask whether it matters whether the practitioner genuinely believes in and values health advocacy, or whether it is satisfactory if the practitioner demonstrates advocacy in her or his actions.[26] Depending on how this question is answered, the question then arises of how best to teach someone to become disposed to advocate for a patient and for a group of patients or a community: is it enough to provide opportunities in which the medical student or resident can practice advocacy activities, or should one seek to inculcate in the medical student or resident an investment in patients' optimal health, including a motivation to assist that patient in navigating the health care system (agency) and to act to improve health determinants for a group of patients or community? I do not want to suggest that physicians are typically indifferent to patients' wellbeing, but Dobson, Voyer and Regehr write that "trainees perceive [the health advocate role] to be less important than other CanMEDS roles [and] have variously described it as charity or as going above and beyond regular duties."[27]

Conclusion

My exploration of the role of health advocate and the questions surrounding the teaching and assessment of the competencies and dispositions associated with this role illustrates that discussions in the field of medical education could benefit from philosophical scrutiny. As Martin indicates, medical education's focus on technical competencies and their reliable assessment is currently being examined as part of critical reassessment and reform efforts.[28] Philosophical perspectives would be helpful not only to retrieve and make explicit the philosophical assumptions and foundations of particular medical-educational practices, but also to help the medical profession reflect more broadly on its social contract with society. In the mid-1990s the Chair of the Association of American Medical Colleges noted that "there is a sense that academic medicine may somehow have failed to deliver on important parts of our social contract, a contract we entered, at least implicitly, by accepting society's generous support."[29] In 2000, William Sullivan put it more strongly, not

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only indicating that the social contract between medicine and society is under pressure, but also arguing that medicine will not be able to restore that social contract by focusing on technical skills and expertise: "If the professions are to have a future, they may need to make their case on the basis of a social and moral rather than a wholly technical understanding of what it is that professionals are about."[30]

By reflecting on these and other developments in medical education, and thinking about the specificity of educating doctors, rather than having an abstract figure of a physician make a cameo appearance in philosophical writing about teaching or other aspects of education, philosophers of education gain a new set of educational questions to work with. Moreover, these questions have relevance for other types of professional education, such as teacher education. If medical education scholars are sounding the alarm about the efforts to restore the public's trust in the medical profession through an increasingly detailed breakdown of competencies and their quantitative assessment, how might education scholars use that work to think about the limits of competency-based systems as a way of restoring public trust in the teaching profession? And why is it that "collaboration" is not an explicit role or professional standard for teachers in the way it is for physicians in the United States and Canada, even though teachers have to work in interprofessional teams with, for example, school psychologists, speech pathologists, social workers, and parents?

Finally, the field of medical education scholarship is a relatively young field, reliant on multiple disciplinary perspectives, and characterized by scholarly collaboration between clinicians (MDs) and non-clinical scholars (PhDs). It has a strong orientation to the practice of medical education, and to using research to examine questions arising from practice. For philosophers of education concerned about the connection to educational practice,[31] turning our philosophical attention to questions arising from medical–educational practice would offer the valuable challenge of seeing how our ideas hold up against the demands of practice.

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1. For example, Benjamin Endres, "The Conflict between Interpersonal Relations and Abstract Systems in Education," *Educational Theory* 57, no. 2 (2007).

2. John Drummond and Paul Standish, eds., *Philosophy of Nurse Education: Towards a Philosophy of Nursing and Healthcare Professional Education* (Basingstoke, UK: Palgrave Macmillan, 2007).

3. David Carr, "Is Understanding the Professional Knowledge of Teachers a Theory-Practice Problem?," *Journal of Philosophy of Education* 29, no. 3 (1995).

4. Ibid., 316.

5. Ibid., 317.

6. I have substituted "thorough knowledge of developmental psychology, sociology of education, or curriculum theory" for Carr's "heard of Piaget, Bernstein or Stenhouse" to allow for a fairer comparison; after all, it is considerably less contentious to claim that it matters little whether a teacher can remember or has ever heard the name of Lawrence Stenhouse than it is to claim that it matters little whether a teacher knows anything about curriculum theory.

7. Carr, "Is Understanding the Professional Knowledge of Teachers a Theory-Practice Problem?," 317.

8. Nel Noddings, "Is Teaching a Practice?," *Journal of Philosophy of Education* 37, no. 2 (2003): 241–251.

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9. Ibid., 244.

10. Ruth Cigman, "How Not to Think: Medical Ethics as Negative Education," *Medicine, Health Care and Philosophy* 16, no. 1 (2013): 13–18.

11. Ibid.

12. Christopher Martin, "To What End Communication? Developing a Conceptual Framework for Communication in Medical Education," *Academic Medicine* 86, no. 12 (2011): 1566–1570.

13. Ibid., 1568.

14. Ibid.

15. Ibid., 1569.

16. Christopher Martin, "Reconstructing a Lost Tradition: The Philosophy of Medical Education in an Age of Reform," *Medical Education* 47, no. 1 (2013): 34.

17. Ibid., 36. See also Christopher Martin "Okay, Well How About Applied Liberal Education? Making a Case for the Humanities Through Medical Education," *Philosophy of Education 2011*, ed. Rob Kunzman (Urbana, IL: Philosophy of Education Society, 2012).

18. Sarah Dobson, Stéphane Voyer and Glenn Regehr, "Agency and Activism: Rethinking Health Advocacy in the Medical Profession," *Academic Medicine* 87, no. 9 (2012).

19. For example, Lorelei Lingard, "What We See and Don't See When We Look at 'Competence': Notes on a God Term," *Advances in Health Sciences Education* 14, no. 5 (2009).

20. Donna H. Kerr and Jonas F. Soltis, "Locating Teacher Competency: An Action Description of Teaching," *Educational Theory* 24, no. 1 (1974): 16.

21. Jason R. Frank, *The CanMEDS 2005 Physician Competency Framework* (Ottawa: The Royal College of Physicians and Surgeons of Canada, 2005).

22. Harvey Siegel, "The Rationality of Science, Critical Thinking, and Science Education," *Synthese* 80, no. 1 (1989): 25.

23. Frank, *CanMEDS 2005*, 20.

24. Shiphra Ginsburg, Wayne Gold, Rodrigo Cavalcanti, Bochra Kurabi, and Heather McDonald-Blumer, "Competencies 'Plus': The Nature of Written Comments on Internal Medicine Residents Evaluation Forms," *Academic Medicine* 86, no. 10 (2011): S33.

25. Ibid., S31.

26. For a discussion of the assessment of beliefs and actions in dispositions, see Claudia Ruitenberg, "The Trouble with Dispositions: A Critical Examination of Personal Beliefs, Professional Commitments and Actual Conduct in Teacher Education," *Ethics and Education* 6, no. 1 (2011).

27. Dobson, Voyer, and Regehr, "Agency and Activism," 1161.

28. Martin, "Reconstructing a Lost Tradition."

29. Spencer Foreman, "Social Responsibility and the Academic Medical Center: Building Community-Based Systems for the Nation's Health," *Academic Medicine* 69, no. 2 (1994): 97.

30. William M. Sullivan, "Medicine under Threat: Professionalism and Professional Identity," *Canadian Medical Association Journal* 162, no. 5 (2000): 675.

31. For example, René V. Arcilla, "Why Aren't Philosophers and Educators Speaking to Each Other?" *Educational Theory* 52, no. 1 (2002).

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