Paper 14

# Extracts from Refocusing Postgraduate Medical Education (Fish, 2012)

## Contents Page, Chapter 3 and Full reference list.

Della Fish 2012





*"Developing a way forward for postgraduate medical education"*

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# Contents

Chapter Three

# Seeing professional practice anew: exploring the nature of education and medicine

Whilst writing this chapter, I was unexpectedly involved, as a patient, in two surgical procedures, one of which turned out to be longer and more complex than either I or the surgeon involved expected. I had chosen to see this consultant, whom I had not met before, privately, in order to be able to fit what I needed from her around my professional commitments. Naturally, I paid a fee for what she did, which I regard as fair remuneration for her technical expertise, and as, in one sense, no different from payments I might make at the point of need for any appropriate service I received, whether from a professional or a tradesperson.

But, I also took her a present. This I saw as a response not to her technical expertise but to the *person she is*, which had emerged clearly even in such a short time, through the way she met and responded to me, from the way she conducted herself and inter-related with me during the unexpected demands of the surgery, and in her reaction to my own relief at some good news. Here she went beyond 'duty' and 'obligation' and met me, whole person to whole person.



## Introduction

In setting out seriously on the demanding journey towards becoming medical educators, the first 'taken-for-granted' ideas that we need to examine more closely and formulate more accurately are about the nature of the professional practices of both medicine and education. This is because how we see the former shapes the kind of doctor we will be trying to cultivate and how we see the latter will become the very bases of all our aspirations, thoughts and actions as a teacher. Thus these matters are an unavoidable starting point for developing a well-founded and well-argued philosophy both for individual medical educators and for PGME itself.

Medicine including surgery, and education, are professional practices. The commonsense view of the nature of medicine is that it is a technical and evidence-

based practice, informed by science and performed by knowledgeable and skilful doctors. Montgomery (2006), however, characterizes this as the myth doctors sell to themselves publicly, whilst privately in their actual practice, relying on a far more complex view of medicine! An educator who accepts unthinkingly this common and commonsense view, will expect PGME simply to focus on the acquisition and development of skills and knowledge. Indeed, this is the instrumental thrust of all current curricula for postgraduate medicine. However, a few seconds review of this in the light of what doctors actually do in practice, will show that this seriously underplays what medical practice demands of doctors, and that whilst such curricula properly require such necessary knowledge and skills to be learnt, this alone is by no means sufficient to cover all that teachers need to work on with learning doctors.

Likewise, the practice of teaching is commonly seen as a relatively simple process requiring the teacher to be knowledgeable in content (which is not a problem in PGME), and to be able to exercise a few teaching skills and strategies in order to 'get that content over'. As we shall see, this is an impoverished and outmoded view of what is involved in learning, because, as educators know, 'telling someone' by no means guarantees their understanding. (See, for example, the work of Carr, D.; Carr, W.; Dewey; Freire; Hanson; Oakeshott; Van Manen, M.; and Wells.) There are even more misunderstandings about education than about medicine, because we often slip into unchallenged assumptions that we know what teaching involves and what the practice of education is all about, having been taught by well-prepared and knowledgeable teachers who *appear* to perform smoothly on the simple basis of their knowledge and a few teaching strategies. The assumption therefore, is that anyone can teach as long as they are knowledgeable and possess a few commonsense skills. But again, a few seconds thought will remind us of some who were knowledgeable, but couldn't.

This chapter therefore seeks to foster a structured exploration of the real nature of professional practice in medicine and education. It does so in four sections, starting with some issues about professional practice generally, before focusing down on the specific nature of medical and educational practice. Thus, we begin by exploring ideas about, and clarifying some terms related to, 'practice' and what we mean by 'professional' practice. In the second section we look at the *nature* of professional practice itself, by exploring ideas that lie at the very roots of educating professionals as seen in two contrasting modes of practising as a professional. In the light of these modes of practice, the third section offers some thoughts about the nature of medical practice and how we might construe it, while the fourth looks at the practice of education in these terms.

## Clarifying some terms: 'practice' and 'professional practice'

In order to clarify ideas that will be captured by certain terms used in this book, this section considers what we might mean by 'a practice', and then by the word

professional in the phrase 'professional practice'. It finally proceeds to look at the traditions of practice in a profession and to explore what is involved in learning in a community of practice.

## *What is 'a practice'?*

The word 'practice', as Golby and Parrott explain, can be used in two major ways in courses of professional preparation (whatever the specific profession involved). It can refer to the *individual activity* or activities of a single practitioner. But, in the term 'professional practice', it is also used to refer to what they have called a 'living tradition' which 'has its own distinctive aims and values' where what people do is intelligible only by reference to (a) their own understandings of what they are doing and (b) the tradition of conduct of which they are a part, (Golby and Parrott 2002: 9). For education, they note, the social project is the promotion of knowledge, just as for the legal profession it is justice and for the medical profession it is health. Using an analogy from everyday life, they helpfully go on to argue that the professional's activities in practice are best understood from within the tradition of professional practice to which they are related. They are at best: temporary; can never be fully solved; are situation specific; are essentially contestable (because value-related); and have a moral dimension. They argue that:

> A practice exists whenever a more or less settled body of activities is carried on to some distinctive end. Activities may be regarded as particular things people do to some overall social purpose. For example, parenthood is a practice (and motherhood and fatherhood too). Within these practices particular activities have their place, a place which may be more or less settled or agreed.
>
> *(Golby and Parrott 2002: 3)*

They cite bedtime routines, methods of discipline, family holidays and excursions, and visits to grandparents as examples of activities which, taken together, give a character to individual parents' practice of parenting. This enables parenting to become something we can talk about, for example, as 'loving' or 'cold', 'permissive' or 'highly disciplined', evidence for this coming from examples of particular activities pursued by the parents in question. Citing the differences in the role of the father in Victorian times and fathers now, they note that 'conventional wisdom about practices changes over time'. Thus, as they show, in engaging in our own practice as a parent, we also contribute to the more general practice of parenting, and such a contribution, they add slightly mischievously but very seriously, is one that makes itself felt most in the subsequent influence it has on our grown-up children and *their* own practice of parenthood. (See Golby and Parrott 2002: 3-4.) This is a solemn reminder of the long-term significance of our educational endeavours.

This is not, however, the same as assuming that when you have listed all the possible activities, knowledge and skill that make up 'a practice', you have summed up what is involved in that practice. It is unwise to extrapolate from this to claim to be able to lay down all that will be needed by everyone on every occasion. That approach to characterizing a job works only where the job requires training as an apprentice, or following a rulebook. But it does not work well for professionals who have to make

complex decisions and professional judgements wherever the protocols run out. In professional practice this occurs frequently, because professionals serve individuals each of whom is in some sense unique.

All this demonstrates why 'good practice' cannot consist of simple pre-specifiable skills and activities, as argued for example by Jessup (1991) who was a leading theorist of skills-centred training, and as found in the competencies listed in most modern curricula of most professions. This view misleadingly assumes that breaking down the explicit aspects of a profession's job into every visible component will provide a formula (the sum of those skills) that will produce 'good' professional.

'Being a professional' will always involve more than a simple sum of the parts. It is possible (and perhaps desirable) to require a basic level of practice, that is a just-acceptable standard for entry to a profession, by setting out a list of skills and knowledge required, and using an inspection and control system to enforce just this. But at postgraduate level, in a professional practice, such imposition is anti-educational, amoral and very un-emancipatory, as well as being difficult to police. It is also de-motivating for all those who are well capable of far more than what is on the list! It is a very technical solution to the problem of establishing a basis for cultivating good professionals and remediating poor ones or dispensing with their services.

But the most fundamental flaw in all this is that good practice is *context specific*, can only be described in terms of principle, and is only achieved *in* practice (dialectically and empirically). This also means that good practice cannot be 'mandated' by decree from outside. (No individual's practice can be rendered excellent by trying to 'inspect quality into' it!) As this book is attempting to show, there are better ways to think about all this and sounder and more educational ways of developing good professionals in practice.

## *What do we mean by 'professional' in the phrase 'professional practice'?*

As Golby argues, learning to become a professional is: 'a matter of coming ever more fully into membership of a tradition of practice' and, 'at its maturity it is a matter of taking part in more fully shaping practice for the future'. This involves understanding the inherited traditions of a profession and considering critically and practically their present relevance. (See Golby 1993: 8.)

Professional practice, as Golby points out:

> is not merely habitual skilled behaviour but a stream of highly miscellaneous activities unified as serving a social good. Practice has a history which can be seen as the collective pursuit of human good; as an historic phenomenon, practices have their own language and style. Though there are of necessity routine and unreflecting parts of daily professional life, loss of sight of fundamental values which have evolved historically in the activities of practice is at once a loss of professionalism.
>
> *(Golby 1993: 5)*

For the current purpose, we need to note that in this book the term professional is

used to define practice as something engaged in by a *member* of a profession. (See Fish and Coles (2005), chapter five, for full details of what this involves). It is also something one is and one lives, rather than a mere label to indicate the group one belongs to.

It follows that in postgraduate medicine, teachers should provide learners with a range of possible ways of construing the kind of professional they are and wish to become and the kind of professional practice they wish to engage in. For resources to aid discussions about professionalism with learning doctors see Fish and de Cossart (2007) chapter five; and Cruess, Creuss and Steinert (2008). *Frame 3.1 Some comments about professionalism*, offers three quotations that might be useful as starting points for teachers and learners to consider. It should be noted that all three raise important issues about how doctors should, *as professionals*, conduct themselves.

**Frame 3.1 Some comments about professionalism**

'We take professionals to be persons who seek a broad understanding of their practice, paying attention not only to their developing competence, but also to the fundamental purposes and values that underpin their work'.

*Prof Michael Golby, Exeter University*

'Professionalism is an aspect of practice that is assessed in all doctors from the Foundation Years to the end of specialty training. It is significant in shaping the relationships with all other healthcare colleagues. It is recognised by the sick as central to the quality of their care, and is a crucial element in patients' attitudes to their doctors....
It is therefore important that doctors in training be enabled to explore, defend and critique the key principles and values to which they aspire and which they intend to use to shape their working lives.

*Profs Della Fish and Linda de Cossart, Chester University*

'A good professional has to be someone who possesses, in addition to specified theoretical or technical expertise, a range of distinctly moral attitudes, values and motives designed to elevate the interests and needs of clients, patients or pupils above self-interest.'

*David Carr, Emeritus Professor, Edinburgh University*

It will readily be seen that in all these comments, the hallmarks of a professional go well beyond mere expertise in knowledge and skill. Medical educators will need to have formulated their ideas about this, because these will become the bases of their educational aims as teachers, and these aims will shape everything that they offer in the name of education.

It is also important to recognize that in joining a practice which like all practices will have developed over time, a learning doctor will need help from a teacher or teachers in making sense of their working context. The following two sub-sections seek to lay the underpinning foundations of understanding in respect of this.

## *The traditions of practice in a profession*

When we work as a professional we are always acting within — or in response

to — the traditions of our practice. This refers to the ways of doing things and of thinking about things that 'are the norm' because they have come to characterize our profession. They have developed over time until the present. (Such development is of course often not linear and not always for the best!) Many of these 'traditional ways of doing things' are the tacit but accepted norms of life in that social group, such that they do not need to be referred to, because they are the 'done thing' that everyone knows about. These traditions are what give complexity and richness to the everyday life of professionals. They shape and give meaning to the situated lived experiences of people like doctors, teachers, and lawyers, all of whom work as professionals with vulnerable patients, learners and clients, and make decisions with and about them. Such work lies in the realm of moral practice.

Examples of the kinds of aspects of practice that capture the range of what is involved in the traditions of that practice include those in *Table 3.1 Some constituents of the traditions of practice*.

**Table 3.1 Some constituents of the traditions of practice**

| | | |
|---|---|---|
| Activities | Agreements | Arrangements |
| Expectations | Frameworks | Habits |
| Informing theories | Inventions | Logic |
| Practice ontology | Priorities | Relationships |
| Routines | Rules | Systems |
| Tacit understandings | Values | What is and what isn't negotiable |

The significance of all this for the teacher of professionals, of course, is to what extent they are responsible for inculcating the norms of the profession into their learners, and to what extent they should encourage criticality, flexibility and more creative thinking. As Benjamin's famous myth 'The Sabre-tooth Curriculum' shows us, (Benjamin 1931) it also raises several interesting dilemmas.

- Is one's responsibility as a teacher to en-culture learners into an unthinking acceptance of the *present* traditions of practice in their profession?
- To what extent and in what ways, as a teacher, should our personal views about practice in our profession colour and shape what and how we teach?
- How, as teachers, should we construe, and how should we encourage learning professionals to construe, the significance of the community of practice within which the professional is working?

These are all moral matters for the teacher that need careful and frequent consideration and review. As we shall see further below, how we respond to them will depend on how, as teachers, we see the nature of education.

How new members of a profession learn these 'norms' is also an interesting issue. Many of them are learnt through and as part of being a member of a community that inevitably learns together in practice. However, this does not absolve the teacher from taking a view about such learning and from acting as guide to the learner in not taking for granted as appropriate all the behaviour that is seen and heard in the practice setting, but rather considering it critically and engaging in it thoughtfully. Thus, doctors learn to practise not merely by being told what to do and how to do it by their teachers. They learn within and from their communities of practice, and their teachers need to understand this too.

## *Learning in a community of practice*

As Wenger (1998) points out, our identity as practitioners is shaped by: the way we talk about our changing abilities; how we see our shared historical and social frameworks; how we participate in the social configurations that confirm our competence; and how we understand the changes that result from our learning.

He then argues that learning in practice includes the following processes for the communities involved:

> *evolving forms of mutual engagement*; (discovering how to engage with co-workers, and what helps and what hinders developing mutual relationships; defining identities; establishing who is who, who is good at what, who knows what, who is easy or hard to get along with)
>
> *understanding and tuning their enterprise*; (aligning their engagement with it, learning to become and hold each other accountable to it, struggling to define what the enterprise is all about)
>
> *developing their repertoire, styles and discourses*; (renegotiating the meaning and importance of various elements, recalling events, inventing new terms, creating and breaking routines).
>
> *(Summarised from Wenger 1998: 5)*

Wenger sees these three dimensions of learning as interdependent and interlocked into a tight system. Medical educators need to take some account of this and open up their learners to such wider awareness.

It would, of course, be easy to dismiss the need for thinking about this range of issues, as matters resting on mere 'common sense' — something to be taken for granted and not worth dwelling on, given that there are patients needing treatment. However, all so-called common sense is in fact grounded in a set of unrecognized, and thus unexplored views, which themselves are *theories* about what is important and about how things are or should be done. (See, for example, Smith, 1992.) It is arguable therefore that the medical educator's responsibility is to develop doctors and surgeons as full and fully-aware members of their profession. In order to do so, they will need to bring such issues — and those that now follow — to the attention of their learners. Indeed, as postgraduate doctors, it is their basic educational entitlement to be supported by their teachers in exploring all these issues (many of which were natural topics for discussion when 'trainees' met regularly, and learnt within, their firm).

## Rival conceptions of the nature of professional practice

This section draws on the work of David Carr (Carr, 2003; 2004) in examining two contrasting ways of thinking about and engaging in professional practice (the technical and the moral mode), and what they each mean for the everyday practice of doctors and the educational responsibilities of their teachers.

The technical mode of practice is engaged in by those professionals who see their job as a matter of dealing with technical problems by providing technical solutions through expertise that depends more or less exclusively on specialist knowledge and relevant skills. In short, they see those they provide for, not so much as *people*, but as technical problems. This assumes that the world in which they work is scientific, objective, and largely mechanistic and well ordered, such that the application of knowledge and skill is a fairly straightforward matter. The aim of a medical educator who thought like this would be to seek to produce a doctor who was a skilled and knowledgeable performer who could solve technical problems effectively and efficiently.

By contrast to this, the moral mode of practice sees the professional as someone who brings their knowledge and skill to the whole person they serve, by relating to them, person to person, with all the human and moral responsibilities that this brings. They also see the world as complex, unpredictable and not yielding so simply to the application of theoretical knowledge and pre-learnt skills. Such a doctor would need from their teachers, in addition to a focus on knowledge and skills, support and nurturing in the development of their character, personal qualities, professional judgement, humane understanding and the flexibility and courage to persist in the face of difficulties.

As we shall see, these contrasting ways of conceptualizing professionals' practice bring with them different concepts, identified through contrasting language, that shape professionals' whole way of seeing the world of their work.

David Carr points out very clearly that there is 'a significant difference between technical and moral modes of practical engagement with the world [but that] almost any human activity is likely to have both moral and technical dimensions or implications'. However, he adds:

> there are nevertheless crucial differences between senses of 'good' as used to qualify character and skilled performance, and between the ways in which goodness of personhood and goodness of technique are measured and fostered.
>
> *(Carr, D. 2004: 106)*

Thus, for example, in the technical mode of practice, 'good practice' is about 'delivering' a performance using pre-set skills, strategies and book-knowledge or formal theory. Here, the question about what makes a good teacher (or doctor), is usually responded to by listing as evidence a vast number of competencies or

skills that are observable and countable, and pointing to a syllabus which lists all the knowledge they should know. This is then expected to cash out into success for the learner, evidenced through 'assessment tools' which are seen as separate from teaching and learning, and which measure the observable and treat that which cannot be observed as trivial. The problem here is that although these things are countable, they cannot be *counted on* to tell us everything about 'quality'. Their sum does not automatically amount to the whole 'good' that we seek for either teacher or learner!

Further, the practitioner who works in the technical mode of practice is merely the agent of — and has yielded sovereignty in a number of areas to — others outside their practice (administrators, bureaucrats, regulators, even politicians). For example a teacher holding this view naturally abdicates to others the responsibility for:

- *what should be taught* (the curriculum on paper is seen as 'to be obeyed' not as a guide which needs endless development)
- *what makes 'good practice'* (the list of skills / competencies and knowledge is accepted as decreed by someone outside the practice context)
- *what is the 'right thing to do'* (the only moral compass we need is seen as obedience to 'the rules' which are treated as absolute and sufficient law).

This way of seeing it converts practice into a kind of applied science or theory-based approach that casts practitioners into the role of technician, and construes professional effectiveness largely as performances of measurable skills. This view is currently highly prevalent, and as Carr, D. (2004) says, it is a view that has been considerably overplayed in the last two decades. It would also seem to be a flawed way of seeing professional practice, since many attributes that are characterized as skills are not skills at all, and would probably be better understood and developed when seen as capacities. An example would be professional judgement.

By contrast to all this, in the moral mode of practice, the good practitioner is constituted of more than knowledge and skills (epistemology). Here, *the person the practitioner is* radically affects what they do and can achieve (with say learners or patients). This emphasizes the ontological dimensions of practice, such that a good practitioner is seen as one who:

- possesses moral awareness about their practice responsibilities
- establishes a human and humane mode of engagement with clients
- is an agent of their own practice because they take responsibility for all aspects of it, and make wise choices about what to do, which may be guided, but are not constrained, by national requirements (by the curriculum if they are teachers — or by protocols if they are doctors).

In the moral mode of practice, the practitioner knows and can make clear their own values, recognizing them as driving their thinking, and has the discretion (exercised with principled autonomy) to make wise judgements for and about the learner / patient in the light of their specific context and their particular needs. In all this, the kind of human being they are, as both a person and a professional practitioner, matters, because they seek to meet the whole learner or patient with the whole of themselves in order to work in their service. Such practitioners develop an understanding of *how to 'be'* with that learner / patient, which is about developing character and personality attuned perceptively and affectively to the moral aspects of the practice experience, and is not about *appearing* to behave like a good practitioner — a demeanour that, ironically, is quickly recognized by both learners and patients!

In this mode of practice, for example, a teacher: is finely tuned to the learner; can support and challenge them; can probe and develop their thinking and moral perspectives; and will attend both to the learner's developing *conduct* (action driven by acknowledged principles and articulated values) and to their character or *personhood*, rather than simply their *behaviour* (action driven by an outside agent rather than by the understanding and conviction of the learner).

The education of a learning doctor under this view, would focus as key concerns, not simply on routine medical skills and knowledge, but crucially also on:

- that doctor's understanding and knowledge of themselves as a doctor
- their sensitivity to the particularities and humanity of each patient
- their ability to establish a therapeutic relationship with each patient
- their awareness that their interpretation of the context(s) in which they meet the patient will profoundly shape their clinical decisions in this case
- their capacity for sound and rigorous clinical thinking
- their capacity for making wise professional judgements that are not compromised by self-interest
- their ability to see beyond the immediate in weighing up the clinical choices available in each case.

Such an agenda might thus offer the learner new ways of thinking and of being, that challenge the status quo of what we might call 'old-style medical education' where teaching is characterized as telling the learner 'the knowledge', where assessment is about counting the learner's skills, and where clinical practice conforms uncritically to protocols. There, 'the given' in medical practice (the current reality of clinical work and its context) is unquestioningly accepted and obeyed. An example would be simply accepting the need to prioritize the demands of clinical work to the point where there was very little if any time for any serious and in-depth education.

These principles of two very different ways of construing practice go back to Aristotle and have been well-recognized by many educationists since — particularly those in the last twenty years who wish to characterize quality teaching and learning in ways other than through competencies, but whose voice has until now been mainly excluded from public debate. (See, for example: Carr, D. 2004; Carr, W. 1995; Cruess, Cruess and Steinert 2008; Dunne 1995; 2005; and Fish and Brigley 2010). If medical education is to move forward it needs to recognize these ideas and work to ensure their implementation.

Indeed, one key insight associated with the moral mode of practice (whether it be educational or medical), is that in order to aspire to change the world for the better in some way (to offer understanding, enlightenment and emancipation; or cure, treatment or palliation) *we have first to change ourselves in respect of becoming agents of our own moral stance instead of being obedient to convention.*

Thus, a moral response, as illustrated by Carr, D. is to:

> get to the bottom of things, and getting to the moral bottom of things is above all a matter of making *myself* more honest, courageous, self-controlled, just, caring, and so on.
>
> [This] is a matter of ... personal change or development on the part of agents, not just of behaviour modification or increase in intellectual knowledge: and such change of heart can be a function of nothing less than coming to see the value of virtue for its own sake...
>
> *(Carr, D. 2004: 107)*

he adds later that:

> such development of self and others involves the reflective refining or enhancement of conduct in complex contexts of human association...
>
> *(Ibid: 110-11)*

So, as postgraduate medical educators, then, how do we wish to construe the practices of medicine and of education? The next section offers some thoughts on the nature of *medicine* as a practice and how we might construe it within the moral mode of practice, while the final section looks at the practice of e*ducation*.

## The nature of practice in medicine and how we might construe it

How might we characterize current medical practice? The following points have in my experience resonated with many doctors who work 'on the ground' within the NHS. They have been adapted from Fish and Coles (2005).

- The reality of the lived clinical experience for doctors is more multi-faceted than simply being about getting the patient better and requires more than textbook knowledge, and the ability to carry out laid down procedures and technical skills.

- Medicine involves, lying beneath the overall categories of differential diagnosis / treatment plans / care pathways, the real detail — the need for important medical abilities and capacities and for personal-professional characteristics and qualities that go well beyond having and applying traditional knowledge and skills.

- Medical practice requires many immediate and highly informed judgements to be made by the doctor with and on behalf of vulnerable and sometimes confused patients, often on the spot and in collaboration with fellow professionals. But judgement is not 'a skill'. It cannot be taught by a lecture-presentation to learners. It can only be nurtured over time through rigorous and deep reflection on experiences in which judgement has been central.

- In addition to traditional knowledge and skills, medical practice demands of doctors a wise mixture of intuition, professional on-the-spot judgement, hunch, and risk-taking. Such wisdom cannot be learnt from a textbook or taught directly. It can only be cultivated over a period of time through professional conversations in which specific cases are reflected upon deeply and from which only working principles can be drawn. This is because principles will travel and will guide practice in other similar circumstances, but learnt skills and knowledge cannot be simply applied in every case. Rather they have to be adapted to each new context — as guided by the sound principles gained through reflection on experience.

- All medical practice is informed by esoteric and complex procedural and propositional knowledge, but this needs to be shaped by recognition of the moral dimensions of working with and for patients and colleagues, (as controlled through the traditional professional parameters for shaping proper conduct, and influenced by the need for accountability).

- Complex medical practice is difficult to learn except through rigorous reflection on specific experience, and even then, although one can illuminate the knowledge embedded in a piece of professional practice, one often cannot fully express in plain words all that has been demanded of the doctor. Metaphors sometimes come to the rescue here, but talking at this deep level can only occur within a nurturing and trusting relationship between teacher and learner.

- In many senses such medical practice involves creativity, and is based upon practical wisdom (which comes from more than mere accrued and repeated experience but which evolves through experience that has been rigorously explored by means of reflection until the deeper understanding of that practice has been achieved).

- It is about communicating with and working with immediate colleagues, and the multi-professional team, and knowing and being able to assess one's own strengths and weaknesses.

- Ironically, the propositional (factual) health-care knowledge called upon in any doctor's individual interaction with patients is often a small proportion of medical knowledge as a whole. It is necessary to know as much of it as possible, and to know

when to use it, but such knowledge is actually one of many resources, all of which need a place in the curriculum for practice.

- Doctors are individual members of a range of professional communities, in each of which they have responsibilities to their fellows. This makes medical practice (and learning it) a social and collaborative enterprise. Such professional communities include, for example, the community of the work-place; of one's specialist knowledge; of one's professional body; and of professions generally.

- Such qualities, characteristics and understandings cannot (except in trivial matters) be satisfactorily categorized in boxes or assessed via tick lists and one-page forms.

In de Cossart and Fish (2005) we summed this up by saying:

> [Professionals] endlessly create, negotiate and develop meanings; have to be appropriately flexible about some things and temporarily inflexible about others; engage all the time with multiple activities, factors, and perspectives; ceaselessly formulate problems and solutions; and learn to live with, the insoluble, the ephemeral, the tentative and the incomplete.
>
> *(de Cossart and Fish 2005: 100)*

Young doctors working in the 21st century need this understanding developed in them, together with wise judgement, in order to make themselves and their patients safe — especially in a world in which patients now have the same access to medical knowledge that doctors do (via the internet) but who may well not fully understand how best to tailor it to their own case.

But there is more to be said. The thesis informing this book (as it also informed Fish 2010) is that both *practising interpretively* and its basis, *practical reasoning*, already exist in medicine but with little explicit recognition, and that they urgently need to be nurtured by means of wise medical education. Practical reasoning or *phronesis* and *praxis* or morally committed action (as we saw in chapter two, pp. 40-41 above), are what the professional engages in so as to make wise judgements in situations of uncertainty. It is the need for such decisions, hour by hour in practice, which makes medicine not a technical practice but an interpretive one. Medical educators who understand this are in the best position to develop wise doctors.

Montgomery highlights the inaccurate avowal of doctors that they practise according to evidence-based medicine. She attributes this to 'a field defect in their vision of themselves and their practice', which she says causes them: 'publicly to "misdescribe" their practice as rule-governed and evidence-based', when in fact the way they work shows medicine to be substantially interpretive. (See Montgomery 2006: 5.) As I argued several years later:

> An unfortunate result of this is that as long as the real nature of that practice (their practical reasoning) remains largely tacit, it cannot be understood, explored and developed, thus depriving beginners of gaining an explicit introduction to it and mature professionals of developing it further.

I also suggested that the result of medicine being an interpretive practice is that:

> This requires professionals (through education) to become explicitly aware of their own values and how these drive their interpretations of practice, even as they engage in it. This in turn enables them to develop further their ability to interpret wisely the complexities of a particular patient's healthcare needs. It also requires them, in the light of this, to formulate and then exercise professional judgment, thus acting with discretion on the patient's behalf, and so recognising and fulfilling their moral responsibilities to the patient.

I added:

> The role of education here is to empower professionals to become more explicit about their tacit practical rationality and more conscious of their values and capacities, so that they can refine and develop them, and can be articulate about their significance in best patient care. In short, through education they become more fully the operators of their own practice and its development, rather than relying solely on the endless updating of knowledge and skills!
>
> *(Fish 2010: 193 - 94)*

What does this assume or require, then about the nature of the practice of education?

## The nature of practice in education and how we might construe it

Perhaps the most important inference from all this is that educational practice, construed as being a moral practice, should be about the emancipating development of self and others, not about the locking of learners into a narrow and narrowing world of the avaricious acquisition of endless skills, protocols and theoretical knowledge!

Education is essentially a values-based concept. This means that it is, to some degree, problematic and not able to be given a once-for-all definition, simply because people use the terms 'education' and 'educated' in approval of an enterprise or person, and their approval depends on what they value most. Thus we might ask the following. Is the term 'educated' to be reserved only for those with Latin and Greek or does being well-mannered matter more? Are we schooled in educational institutions but educated by life? The problem here is that different people value different aspects of life and therefore of education, so that medical educators work amidst a conflicting set of educational values. Thinking about all this prompts educators to have a view on what educational practice means for them, to seek to nurture learners to understand these complexities, and to choose wisely what kind of a professional they might aspire to become. To be able to articulate this for a range of important audiences and purposes is a vital part of being an educator.

Further, these issues should not be ducked in the name of everything educational being merely 'contestable and therefore never able to be resolved into any kind of consensus'. It is the view of this book that while there are deeply contrasting views about education (because, as we shall see, it is values-based), this does not preclude coming to some general agreements, about a number of important and fundamental

matters, in which a range of views can be encompassed and incorporated, to the benefit of all (see Carr, D. 2010).

### *The importance of values — educational, and indeed, professional*

Values are those abiding and long-cherished views we all have — but do not necessarily share — about what counts as enduringly worthwhile and important. These views and values shape our practice, whether we know it or not. They are usually tacit, often lying deep beneath the surface of our practice.

Values are by definition matters of contention, because often they are not shared by other members of our working environment. (It is true that any healthcare professional will share many values with immediate colleagues, but this may not be true across professions, let alone in relation to other staff and to patients.) Indeed, everyone who works in a professional practice lives at the centre of a web of complex, but subtle and largely invisible pressures that arise from the differing values endemic to professional practice and its management, (see de Cossart and Fish 2005: 20).

Values are rarely directly discussed, (so that colleagues do not recognize their differences as values-based), and so the pressures that arise from them are not traced to source and thus become puzzling as well as frustrating. Indeed, contention about values results from seriously different ways of seeing the world, and leads to very different ways of conducting ourselves.

Whether we are aware of it or not, educational values lie at the centre of how we conduct ourselves as teachers, and clinical values are central and fundamental to the professional practice and expertise of doctors. It is thus the unavoidable responsibility of the teacher of postgraduate doctors to have made explicit both sets of values as enshrined in their own practice, and also to recognize that they may espouse some values that they do not manage to attain. That is, as teachers we should begin any attempt to understand and develop any professional practice, both by exploring our own educational values and by recognizing the clinical values we seek to promote. Only then will we be equipped to enable learners to explore their own professional values.

Such an exploration is bound to begin by looking at the visible elements of what a practitioner does, and then attempting to gain access to and understand what drives these. Practitioners rarely talk or write directly about their values, yet, what they do, know and think, speak volumes in respect of what they believe is important. Indeed, ironically, that which practitioners take for granted, and overlook (because it is so much a natural part of their practice), is often very visible to patients, learners and other colleagues who observe them. (See Fish and Coles 2005, chapters three and four.)

## *Making our educational values explicit as a basis for educational practice*

Our *professional* values in general are how we each consistently see the world in which we engage in *professional* practice, and what we prioritize in our professional life. Our professional values are what drive our professional actions, attitudes, thoughts and beliefs. And one's conduct reveals these values to all those one works with (colleagues and patients). Such values existed well before one became conscious of them, and whether one is aware of them or not, they have a profound effect on how others see one. They might also be seen in our views about the ways others engage in practice.

Our educational values shape how we each conduct ourselves as a teacher in the clinical setting. And it should be noted that clinicians working with learners in the clinical setting are *always* teaching their own values (indirectly by modelling, if not explicitly through discussion). Our educational values spring from our own educational experiences which will have shaped how we see the role of the teacher, how we think about teaching as a practice, how we conceive of what learners are like and what they need, and how we envisage assessment as a practice. All this will affect how we each teach and learn and what our learners gain from their time with us.

Sometimes our *actions* as teachers reveal educational values that are different from those we would say we hold. (We might claim to value the learner's views, but how we behave towards them might tell them that we do not!) Here there is a gap between our espoused values (values we claim to hold) and our values-in-use (values that emerge from our practice). Whilst our espoused educational values and our educational values-in-use are in harmony, there is no conflict. But this is rare, and something to strive for rather than something we can easily attain. When we recognize such a values gap, it is always worth exploring further both our practice and our values.

## *Education as a moral practice*

When education is seen as a technical practice, it focuses on the teacher learning a range of skills and strategies for given situations and using them efficiently. When seen as a *moral activity*, it is held to be undertaken in pursuit of *educationally worthwhile ends*, which aim to realize morally worthwhile virtues. Examples of this are as follows.

- The role of the educator is to facilitate the process of growth in the learner (to enhance individual freedom, develop autonomy and contribute to democracy). See, for example, the work of Dewey.
- Education liberates individuals and facilitates their transition from passive to active learners. See the work of Carr, W; Oakeshott; Palmer.
- Education is emancipatory, cannot be morally neutral, and is always directive (but

the ends and means used can be liberating). It is a social process and above all it is the practice of freedom in which learners discover themselves and achieve their humanity. See the work of Freire.

As we shall see in chapter four, these worthwhile ends, aims or goals of education include the development of the whole person and particularly the *cultivation of the mind*, which means developing understanding which in turn will lead to the development of practice.

## Modes of practice in education and medicine

It is important to explore and clarify the relationships between the technical and the moral modes of practice, and these are expressed below in *Figure 3.1 Understanding modes of practice in medical education: a continuum.*

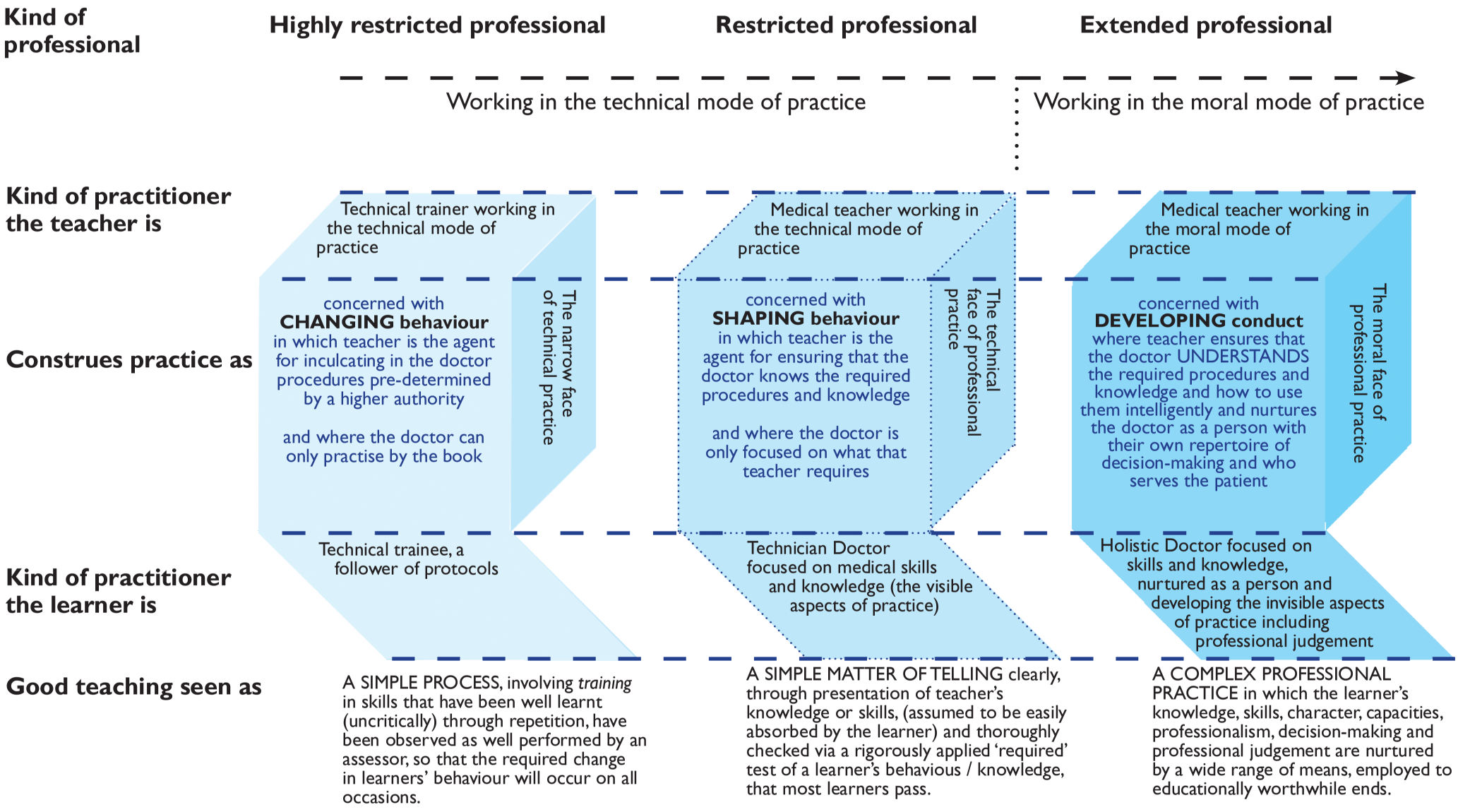
Here the three cubes depicted represent three ways of construing a teacher's practice, and demonstrate the relationship between these as along a continuum. The left hand cube represents a 'narrow training' view of the technical mode of practice. Here, the focus is strictly and exclusively upon training the trainee in the technical skills and the specifics of the specialist knowledge associated with professional practice. This is the most extreme version of the technical mode of practice and is found in the work of the technical trainer who is concerned only with inculcating change in the trainee's behaviour, so that they adopt, follow and ultimately even teach *protocols* as *the* basis for coping with complex practical problems. This is more appropriate for craft apprentices than for doctors and when used in medicine will result in highly restricted professionals unable to exercise the kind of professional judgement needed by patients.

The middle cube represents the views of the medical teacher working more broadly in the technical mode of practice. But visible behaviour rather than conduct shaped by the learner's values, is still the priority. Here the teacher may be trying to re-shape the learner's behaviour in terms of broader skills that need to become automatic and to inculcate extensive specialist knowledge in the learner. This seems less narrow but still produces technicians who are, arguably, restricted professionals.

The view of professional education represented in the right hand cube is that professional judgement is the central core of professional practice and that developing this in learning doctors requires the teacher to work in the moral mode of practice where the development of the learner's conduct, character and understanding are of priority. Here the teacher aims at developing a holistic doctor who meets patients as one human being to another and can utilize their knowledge, skills, and judgement creatively in their service. Such a doctor is seen as an extended professional.

Perhaps the most important aspect of *Figure 3.1*, is that it indicates the possibility of the teacher moving along this continuum from left to right, and also shows that the right hand cube does not eschew the technical aspects of practice.

**Figure 3.1 Understanding modes of practice in medical education: a continuum**
(After the work of Carr, D. 2003)
(All modes may be needed but the educated teacher chooses them in an informed way)



## Last words

These ideas are only a starting point and many of them will be explored further in a range of different ways throughout the rest of Part One, whilst Part Two will consider the practical implications of all this, and will offer examples and suggestions for how all this can be translated into practice.

## Further reading

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