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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

What Might It Mean to Embrace Emancipatory Pedagogy in Medical Education?

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Abstract

An emerging and important goal of professional health training and education is to develop a workforce that is equipped to address patients' social and structural determinants of health and to contribute to health equity. However, current medical education does not adequately achieve this vision. Emancipatory teaching, as described by scholars such as Paulo Freire and bell hooks, equips students with tools to identify and challenge oppressive systems. It helps students achieve freedom for themselves, thereby contributing to more emancipatory and humanistic patient care. Changing teaching in this way would help reverse implicit curricular values that tend to enshrine hierarchy and oppression. Humanities and bioethics scholars working within health professional schools thus should promote a more critical, emancipatory pedagogy in their institutions.

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Educating for Equity

Modern medical education seeks to combine rigorous scientific instruction with skills training in humanistic care and health advocacy.[1] A critical emerging goal is the development of a physician workforce trained to address health inequities—differences in health outcomes across demographic categories, including race, class, religion, and gender identity.[2] This training requires understanding forces that work against physicians' promotion of justice and freedom by restricting their full recognition of patients' humanity—including macro forces like structural determinants of health and micro forces like implicit bias.[1,3,4,5] Curricula addressing these forces are often developed by (or with input from) faculty with backgrounds in bioethics and the humanities. Yet very little pedagogical consensus exists on best practices to advance these challenging goals.[1,3,6]

Medical instruction remains rooted in important but dated bioethical principles, such as respect for autonomy, beneficence, and distributive justice. Concepts arising from Black,

urban, feminist, and queer bioethics (among others) can identify problems and create more expansive visions for physician behavior.[7,8,9] However, bioethics scholars often stop short of putting forth concrete implementation models for substantive practice. Moreover, medical education implicitly teaches hierarchy and oppression through a hidden curriculum because it is rooted in a hierarchical, oppressive pedagogical approach.[6,10] This curriculum's implicit norms teach students to unconsciously infringe upon patients' freedom,[10] further entrenching the inequality they will eventually be tasked with solving.

This article will examine critical pedagogy and the inadequacy of the existing model of medical education to advance the causes of justice and freedom as expressions of health equity. After examining key ideas of critical pedagogy, we describe several ways the educational system enacts the opposite of justice and freedom—oppression—to which both students and patients are subjected. We argue that models of emancipatory pedagogy should be adapted to medical education with the goal of teaching future physicians to be free thinkers and conscientious actors who can, in turn, promote freedom for their patients. Rather than operationalizing traditional bioethics principles, such as respect for autonomy and beneficence, medical education should adopt more radical concepts such as agency, humanity, and liberation.

Emancipatory Pedagogy

Pioneers of critical and emancipatory pedagogy, such as bell hooks, Paulo Freire, and Henry Giroux, have long argued that education should be actualized as a practice of freedom.[11,12,13] Counteracting education that can legitimize, reinforce, or even create systems of domination,[11,12,13,14,15] emancipatory pedagogies equip students with tools to identify systems of oppression in their lives and the greater society.[11,12] When knowledge is combined with active processes of reflection and action, education becomes a process of liberation.[11]

Critical pedagogy asserts that the hierarchy of traditional education dehumanizes students by treating them like empty vessels to be filled with the teacher's "true knowledge." Paulo Freire coined the term "banking concept of education" to problematize this process, whereby students passively and uncritically receive information from a teacher presumed to be more expert than they.[11] By contrast, in emancipatory pedagogy the teacher is a facilitator and guide for learning rather than a director.[11,12] Deference to authority and passive intake of information give way to "problem-posing" forms of mutual discovery. The students and teacher participate in praxis: a cycle of reflection upon the origins of injustice, actions to change it, and reflection upon the actions' effects. Special attention is paid to power and to positionality—how teacher and student are shaped by the world[11]—which increases students' awareness of systemic oppression, its influence on individual interactions, and its coercive silencing of freedom.[12]

Importantly, critical pedagogy balances the inherent power differences that accompany or develop from knowledge.[11,12] Teachers learn and practice in solidarity with their students, constantly attentive to their own position and working to address power imbalances when possible.[11,12] Simultaneously, students learn to identify and resist ways that their new awareness could be used to manipulate or oppress others. Through this reciprocal learning process, students actualize a sense of their own freedom and become equipped to assist others to do so as well.[11,12]

Freedom From . . .

Historically, medical education has epitomized the "banking model," insofar as it propagates a knowledge hierarchy that implicitly dismisses input from those who have not yet achieved the designation of expert, as well as those, such as patients, who never will. Overdependence on the banking model disempowers medical students as authors of their own professional development and represents an implicit devaluation of knowledge generated by those not included in the process of medical education. Moreover, the banking model is overly reliant on didactic coursework and an assessment structure that focuses on quantification and ranking, which minimizes or even denies the relevance of instilling in students humanistic characteristics known to benefit patients, such as reflexivity and sensitivity to power dynamics.

Although medical education has recently embraced small-group discussions and problem-based learning as innovative ways to augment or ameliorate the limitations of the didactic approach, these innovations, while important, are not a panacea.[15,16,17] The hierarchy of knowledge remains embedded in what is, admittedly, a more collaborative approach to learning. Group learning is often designed by faculty and assessed based on faculty members' perspective. Group learning thus reinforces the underlying assumptions that there are correct answers, single or universal truths, and that the most experienced people hold the keys to the discovery of these truths. Currently, discussion-based educational activities hold many of the same risks as traditional educational practices.

The use of the banking model in medical education also disempowers patients as experts about their own bodies. Medical students, trainees, and students in allied health professional programs achieve the status of expert by following the accepted pathway of undergraduate and graduate education. Patients, however, have no mechanism to assert such expertise. Their own illness narratives, symptoms, and perceptions of their illnesses are subordinate to both the objective data physicians can collect about them and physicians' interpretations of these data.

It is notable that students begin school with a cadaver that is described as their "first patient."[18] Cadavers create the first opportunity for data to flow unilaterally from the silent patient to the student for interpretation and ascription of meaning. Students implicitly and explicitly learn to objectify patients as problems to be solved, collections of demographic data points from which to make assumptions—or, in the case of standardized patients—actors to practice on.

Medical trainees receive far more evaluation and feedback from other physicians than from patients on their skills. Proactive efforts to involve living patients in clinical skills assessment is a positive step but still embodies problematic power dynamics. As in problem-based learning, the role of the faculty evaluator remains unchallenged. The attending physician mediates the interpretation of the patient interaction through the lens of the establishment. As a result, a potentially dangerous status quo is maintained wherein physician knowledge supersedes patient knowledge, even when physicians themselves become patients—especially physicians in marginalized bodies, as in the case of Susan Moore, who died of Covid-19 after being disbelieved, despite her professional status.[19]

Envisioning Emancipation

We refrain from offering a specific roadmap for how to teach using emancipatory pedagogies—to do so would be to replicate the very knowledge hierarchy that we argue against and to fail to acknowledge that each classroom is its own unique body, with each teacher working from their own position and set of experiences. However, we offer suggestions for beginning a journey toward radical pedagogy. Emancipatory education requires several forms of interconnected work. The first is *personal*. Educators can become more knowledgeable by engaging with the teachings of experienced critical pedagogists. They can translate knowledge into practice by critically engaging with the limitations of other scholars and with how their own identities mediate interpretation. The second is *interpersonal*. Educators must learn about their students as individuals and practice nonhierarchical interaction, such that they are disentangled from the learned position of "knowledgeable authority." They should actively seek to learn from students as well as about students, helping to create an environment of responsiveness and to engender solidarity. The third is *collective*. Educators must engage in continuous practice to improve the sense of safety that lays the foundation for emancipatory classroom spaces.

In our own work, we envision the classroom as a body. We monitor the classroom environment for signs of "health"—such as cohesion, respectful exchange, and openness to mistakes—and actively address signs of "disease"—such as distraction, disengagement, self-segregation, or intolerance of difference. Transparency about one's intentions to adopt emancipatory pedagogy and encouraging real-time feedback from students about teaching and classroom structure can promote a healthy collective identity wherein all share the title of "learner." When meaningful suggestions from the teacher or students are taken seriously and incorporated responsibly, trust and motivation for learning can be further built up.

Emancipatory education represents a radical paradigm shift that will require its own praxis to implement properly. The emphasis should be on improving the process and accepting progress over perfection. All of us, as teachers, must model a deep humility arising from our awareness that the social problems embedded in medicine were hundreds of years in the making and cannot be dismantled in one course or small-group discussion. Simultaneously, we must take seriously our role in the iterative action of praxis by pushing colleagues to see the connection between the way we teach and the likely outcomes for both students and patients. In a field that is very insular, we can raise our multidisciplinary voices to create awareness of the social impact of education on our institutions, trainees, patients, and communities.

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