From Adult Education to Medicine: Praxis across Disciplines

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Abstract: *This paper provides a model based on the literature and personal experience, arguing for direct application of adult education theory to the practice of a profession. Praxis is therefore not confined to the educational approach for the adult educator of professionals.*

There is ample advice on the translation of adult education theory into the practice of adult education. There is less advice on the theory to practice interplay of adult education theory and the practice of a given profession. What happens when the practice of a profession conflicts with the theories of adult education? What is the value of an education that liberates, for instance, when the professional practice that immediately follows is oppressive? The purpose of this exploration is to examine the translation of adult education theory into professional practice, specifically medical practice. The model that I propose posits that adult education theory can and should directly instruct professional practice. (Praxis not limited by disciplines). I will first review some of the conflicts between the professional practice of medicine and the principles of adult education. These conflicts would not be resolved by merely focusing on the educational processes of the profession. Translation of adult education theory to the theory and practice of a profession, however, has the potential to reduce the discordance between adult educational theory and subsequent professional approaches.

The theory advanced derives from my experience as a surgeon, medical educator, and student of adult education. Initially, pursuit of the study of adult education led to awareness and changes in my practice as an educator of medical students and postgraduate medical trainees. Increasingly, however, I realize that the theoretical underpinnings of adult education provide insight into the actual practice of medicine. The evolution highlights the arbitrary but real limit that professional disciplines place on the praxis, or informed reflection and action on the world (Freire, 2000). The example and perspectives I provide are based on theory that focuses on the import of social interactions in the construction of knowledge and reality (Mead, 1934; Berger, 1966; Vygotsky, 1978).

Professional Practice of Medicine

Classically, physicians "evaluate and treat" medical problems. We develop an "assessment and plan" based on a medical problem list that we generate after interviewing and examining patients. Prescriptive plans are derived from relevant evidence published in the medical literature. The physical and psychological balance of power is shifted far to the physician rather than the patient. Patients that don't follow the prescribed plan are deemed "non-compliant". In the extreme example of power, patients permit surgeons to physically enter and restructure their body, yielding complete control over their very existence. In my experience, the solemn responsibility involved in this process is not lost on most physicians and other participants in the healthcare process. It bears clear mention that countless people are helped in remarkable ways every day through the hard work of those in the healthcare field.

Despite the many successes of medicine, there are certainly suggestions of problems in the system. Socioeconomic status is clearly associated with the health outcomes of mortality and

morbidity. Socioeconomically disadvantaged people die more often and have more health problems than the privileged (Mackenbach et al., 2008). The pattern of disparity prevails across nations and health care systems. Further, the differences are difficult to explain by the prevalence of known medical risk factors. Gender and race are also routinely associated with disparate health outcomes when studied (Wamala & Agren, 2002). Although these disparities are widely known and the causes debated, they present a conundrum for the critically reflective adult educator engaged in the education of physicians. How does one educate professionals under specific societal expectations without perpetuating the inequity?

Freire (2000) describes prescription as one of the essential components of the oppressor and oppressed relationship. Prescription involves "imposition of one individual's choice upon another, transforming the consciousness of the person prescribed to into one that conforms with the prescriber's consciousness" (Freire, 2000, p. 47). The relationship that Freire describes is strikingly similar to the typical physician-patient relationship. Ramifications of the same relationship are described by Diekelman (2002), who provides illustrative cases that demonstrate the implications of the power and oppression that sometimes accompany well-intentioned health care. Depersonalization, central to the Freirian concept of the oppressor-oppressed relationship, is also commonly described in the health care environment. For instance, patients undergoing chemotherapy note the dehumanizing, factory-like system of the treatment (McIlfatrick, Sullivan, McKenna, & Parahoo, 2007). Medical students' first course is often gross anatomy, which is a remarkable experience in many ways. Viewed through a Freirean lens, the work on cadavers in medical school may provide the introduction to the dehumanizing physician-patient relationship.

That the theory of Freire would provide insight into the healthcare relationships contributing to social inequity is not surprising. The more difficult challenge follows, and that is: What should the educator for the profession do with this awareness? My contention is that if the praxis is isolated to either the discipline of education or medicine, the theory that instructs action will be incomplete. The cycle of reflection and action will remain uninformed until the arbitrary disciplinary bounds are dissolved. What follows is an example of this approach in practice.

Application

It is the realization of the shortcomings of classic medical decision making that served as the impetus for the development and administration of a program to medical students which utilized adult education theory to instruct medical practice. The many forces exerting influence from within and without the physician-patient relationship are more evident when considering medical care in the same way that I now consider education. The first formal application of theory from the adult education literature to the practice of medicine focused on medical decision-making. Sork's model of educational program planning involves a three tiered interactive model consisting of the technical, social-political, and ethical domains (Sork, 2000). Rather than simply applying Sork's model to the educational program planning process in medical school, the model was provided for medical students to apply to medical decision-making. The "technical" domain in medical decision making process corresponded with concepts typically taught in medical school and medical texts. Social and political forces, broadly defined, were introduced as an interactive domain influencing the technical aspects of the medical decision making process. The ethical domain is employed to resolve ethical conflict discovered through a robust understanding of the technical and social-political domains.

Traditionally, the influence of social and political forces in the medical decision making process are viewed as pertinent in the extreme and often as problems without recourse. Ethical discussions in medicine also tend to focus on the exceptional cases, such as those surrounding the end of life. Sork's model emphasizes the routine influence of social and political forces, and this is particularly instructive to the medical care process. Combined with readings that provide insight into the basic construct of the social relationships, learners explored the insidious forces that impact the healthcare process for any given patient.

The program employed a constructivist paradigm and clinical case scenarios as source material for discussion combined with reading from the sociology literature. Learners explored the influence of personal factors, power balance in relationships, and societal influence on the healthcare process. Learners also debated the impact of practice guidelines and who determines guidelines. They explored the ways that society enforces expectations of physicians. Health disparities of many varieties were considered along with potential etiologies. My intent is not to summarize the student's exploration, but rather to provide a sampling of the range of topics generated and discussed.

The translation of Sork's model of program planning into a model of medical decision-making is not an endpoint, but rather a beginning. It is a first attempt to meaningfully incorporate theory from adult education into the professional practice of medicine; a dialogue of theory and practice without the disciplinary boundaries of education and the profession of medicine. There are many aspects of the profession of medicine that would benefit from a similar, nearly direct, interface between adult education theory and professional practice.

Disciplinary Boundaries: Arbitrary Yet Real

The assertion that the disciplinary boundaries of education and the practice of a profession are arbitrary warrants further exploration. Although I do maintain that we construct arbitrary theoretical boundaries that compartmentalize praxis, there are practical barriers to cross-disciplinary praxis even if the disciplines are contrived. Professionals, whether educators, physicians, or otherwise, serve as agents of societal institutions (Scott, 2008). They serve to recreate societal structure and professional roles through action. The institutional framework of society includes mechanisms to coerce and enforce behavior. Scott (2008) describes how this enforcement is lived through normative, regulative, and cultural-cognitive aspects of the institution. Holtman (2008) focuses more specifically on the normative aspects of medical professionalism, citing the inseparable nature of medical professionalism and societal pressure. Current professionalism curricula within medical education are largely focused on rules and behaviors (Coulehan, 2005).Although professionalism may connote exhibited endorsement of societal views, professionals are often allowed the leeway to innovate and instigate change. For instance, professionals are positioned within society to allow the introduction of new theory in support of institutional change. That is not to say that the new theory will be routinely welcomed or endorsed.

The professions of adult education and medicine have unique theoretical guidance and societal expectations. Merging of theory and action for the professions is therefore more than a perspective change. Incorporation of new theory into a profession is an active process. Wenger (1998), in his discussion of communities of practice, highlights the concept of participation and reification as two channels of power available for community participants to maintain or influence group behavior. Participation may include a number of interpersonal actions within the

group ranging from rampant discrimination to ambition. Reification involves structural relationship issues such as policy and administrative activities. The overriding point, however, is that both maintenance and change of the community's practice are active and dynamic processes. Effective introduction of a foreign theoretical lens to instruct practice in a professional community will almost certainly require effort and introduce changes in power.

Corresponding with the association of action and power, Cervero and Wilson (1994) define power as the capacity to act. They suggest that challenges of power within a group should be appropriately resourced (Cervero & Wilson, 1996). Brookfield (2005) adds that "knowing that challenging dominant ideology risks bringing punishment down on our heads is depressing and frightening" (p. 8). Introduction of new informed practice into a community of practice, therefore, can be expected to alter power relationships. For the introduction of new informed practice to have a chance of success, power struggles should be anticipated and preparations made.

I have experienced all of the forces described by Scott, Wenger, Lave, Cervero, Wilson, and Brookfield through the described application praxis across disciplinary boundaries. Perhaps most interesting to me was the unanticipated forces associated with the cultural-cognitive framework described by Scott (2008). Learners or others out of the typical position of power may attempt to exert a normative force to squelch attempts to forward theory that redefines practice for the group. I highlight this part of my experience because I believe there is a natural tendency to anticipate and plan for power struggles within the leadership structure. I have now come to expect that introduction of interdisciplinary praxis will stimulate power struggles based on the cultural-cognitive framework from unpredictable actors. More than simply suggesting that maneuvers through institutional rifts and navigating perturbations of power requires an active process, I would highlight that the process can at times be wearing. Values and beliefs protecting the lived demonstration of reflection come under personal attack from without and within through the process of induced change.

Discussion

Adult educators of students entering professions face unique challenges. The practice of the target profession and the educator's theoretical beliefs about adult education may be frankly contradictory. Brookfield (2005) describes the theoretical quests that evolve out of our "desires to explain and resolve the practical contradictions and tangles that consume how we approach helping adults learn" (p. 10). This has been the beginning of just such a quest. The clamor of discussion regarding health care inequity commonly argues to include the disadvantaged, but few voices are heard arguing to favor the disadvantaged or oppressed. The theoretical and practical literature in adult education provides these voices.

The proposed model of interdisciplinary praxis is an evolving model that advocates application of theory from the adult education literature directly to the practice of a profession. Interdisciplinary praxis is necessary, I believe, if we are to scrutinize and act on our professional practice in the same way that we scrutinize our educational practices. We should not limit our ability to transform the world around us by obliging internalized theoretical-practice boundaries.

The provision of a single example herein may paint a picture of an overly optimistic modernist framework where critical reflection in my practice purportedly normalizes societal inequity. Trust that I hold no such optimistic view. Freire (2000), earlier used to support my arguments, explicitly states that the oppressive class "can free neither others nor themselves" (p.

56). By this account, I can accomplish nothing meaningful for society in my example or any variety thereof. Nonetheless, the next day comes and the hope that we might in some way resolve the perceived "tangles" through informed action drives change if not success.

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