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POSITION PAPER

Teaching Fearlessness: A Manifesto

D Wear¹, J Zarconi², N Dhillon³

¹*Northeast Ohio Medical University, Rootstown, Ohio, USA*

²*Summa Health System, Akron, Ohio, USA*

³*Riverside Methodist Hospital, Columbus, Ohio, USA*

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ABSTRACT

Context: Negative role modeling is a plague medical educators fight once students enter the clinical arena. The literature is replete on the fact that students routinely encounter faculty who display attitudes and behaviors inconsistent with the values taught throughout the medical curriculum, particularly in the preclinical years.

Approach: Using a back and forth between the text of a third-year student's reflective essay and two of her faculty's observations on her negative encounters with several clinical faculty, the authors propose 'teaching for fearlessness.'

Discussion: Using Papadimos and Murray's use of 'fearless speech' derived from Foucault's thinking on *parrhesia*, the authors build a case that students should be encouraged to expose and challenge inequities on behalf of their patients, themselves and the profession at large.

Conclusions: Medical educators should model and provide students with opportunities to develop and use 'fearless speech' as a way to reshape the culture of medical education and patient care.

Keywords: Curriculum, medical education, mentoring, professionalism, teaching.



It scares me to think that these physicians were once in my shoes and maybe had the same thoughts as I do, but then someday when I reach their position, is this how I will evolve?

Context

We have all cringed when a medical student tells the story of a remark or behavior she has witnessed, usually in a clinical setting, which goes against everything we have tried to teach and model. These stories often involve attitudes toward patients, but they also include treatment of students themselves such as pimping, public humiliation or other forms of mistreatment. We understand the resignation many students feel at their perceived helplessness to challenge such attitudes and behaviors, and acknowledge the very real implications of 'whistle blowing.' We offer forums for students to discuss or vent their disappointments and frustrations at a training environment that does not always meet their expectations. We ask them to reflect, over and over again, about the things they see and hear. But what we do not offer students enough of is the solidarity and safety—the *fearlessness*—they need to act on the values they bring to medical school, those same ones we hold up to them throughout their medical education.

*From the moment we enter medical school, the authorities beat us over the head with the concept of professionalism, and someone just stands in the front of the room and reads out this long definition with big words about what it means to have a professional demeanor. But I think they also need to add a disclaimer saying 'all of the above holds true, but please don't mind us when in a couple of years, you see us **willingly** not live up to our own standards that we've set for you, even while we force you to accept them.'*

So reads an essay written by one of our students (ND) when she was a third-year medical student (throughout, all her words are in italics). As course directors for a 'Reflections on Doctoring' course spanning all four undergraduate years in the medical curriculum (JZ & DW), we have spent years crafting what has become a pliable, always-evolving curriculum that focuses on reflection on self and profession. In the essays required for each class, sometimes we get exactly what we ask for in our students' writing, including painfully honest assessments of the learning environment such as the one found above. This was not the first time we had heard the phrase 'beating us over the head' with professionalism¹, but this more recent observation from a thoughtful student caused us to look more intently than before on the various, unspoken and often contradictory assumptions we enact in our teaching and the way such teaching is interpreted by students.

Teach, from the Middle English *techen* meaning to show, instruct (from Old English *tæ?can*) has a fairly wide range of meanings. Merriam-Webster defines 'teach' as to cause to know something, to cause to know how, or to acquire some action or attitude. Teaching is usually associated with the triad of knowledge, skills and attitudes found in virtually all educational settings. Synonyms and related words for teach include educate, indoctrinate, instruct, school, train, tutor, coach, mentor, drill, fit, ground, prepare, prime, qualify; direct, guide, lead, rear; catechize, lecture, moralize, preach; implant, inculcate, instill. While the words seemingly have widely divergent implications (the connotations of 'educate' and 'preach,' for example), the differences may be more a matter of personal interpretation given the disparate orientations, responsibilities and goals of medical educators. All of us would say we teach, yet we engage in this activity in very different ways. The basic scientist behind the podium may be *educating* or *lecturing* students about a complex bit of knowledge; a PBL faculty member may be *coaching*, *mentoring* or *guiding* students to puzzle comprehensively and systematically over a multifaceted case; and a clinical faculty member at the bedside may be *instructing* or *drilling* students on various algorithms for making a diagnosis. At any given moment, we are all likely to be implicitly or explicitly moralizing and enacting very particular values through our choices of words and texts, our attitudes toward various concepts and ideas, the examples we use, what we choose to talk about (and remain silent about) and the quality of our attention to persons with



whom we work, teach and offer care. Students pay attention to all of these, processing their observations with the values they already have, which contributes to the kinds of physicians they will become . . . or hope *not* to become.

As medical students, we are like teenagers growing up, still learning about the world of our own that is out there. It is the most impressionable stage of our development as physicians. We are constantly changing with each encounter, each opinion, each day. And we look up towards our teachers and attendings as parents in several respects, especially to guide us rightly to deliver the most appropriate patient care. We as students expect our teachers to set the right standards and follow them through just as there are expectations of us to be 'professional.' And I think this issue should be taken just as seriously with the teachers who take our showing up without our white coats for a simulation to be so 'unprofessional.'

Approach

How might faculty answer these observations and the call for the kind of 'professionalism' scrutiny of *their* behaviors, the same kind to which students are currently subjected? How might we address more thoughtfully and self-critically the fact that our students are, under our watch, at 'the most impressionable stage' of their professional development? How might those of us who focus our professional lives on teaching create a new way of thinking, indeed a new *language*, to describe what we hope to achieve through our formal and informal teaching?

There is clearly a cadre of academic medical educators who have, during the past quarter century, directed their attention to the professional development of students, even as we can all acknowledge that the very term 'professional development' has no universal referent. The proposed vehicles for such development have included specific disciplines, most notably the medical humanities and bioethics, the behavioral and social sciences and all varieties of professionalism mandates, position papers (e.g. American Board of Internal Medicine's *Project Professionalism*) and rituals (white coat ceremonies). Indeed, an industry has grown up around defining, teaching and assessing professionalism, even as the literature continues to point out how, historically and currently, many of the behaviors and attitudes students encounter in clinical settings actively work against such efforts. Nearly 20 years ago, Renee Fox² called these efforts largely compensatory 'magic bullets,' which may still be the case given the corporate vocabulary awash in the curriculum and adopted by many medical educators today that includes 'best practices' and 'key performance indicators,' along with an ever-increasing emphasis on measurable outcomes, competencies and evidence, even for professionalism³.

Yet, in spite of the fact that we 'beat [students] over the head with the concept of professionalism,' students routinely encounter faculty who display attitudes and behaviors that would get students in plenty of trouble if they enacted the same. The literature on negative role modeling includes not only the tendency of some clinical faculty to demand more of their students in doctor-patient relationships than they do of themselves⁴, but also the randomness that allows only some students to find positive models⁵ and the difficult circumstances of students who choose the wrong role models to emulate⁶. One article reports the disheartening news from students at two medical schools that 'most of their teachers did not display . . . humanistic characteristics'⁷; another found that 'the most common transgressions of faculty professional behavior reported by students were the use of derogatory commentary directed at other services, at patients or toward a patient's family'⁸. And a recent study of clinical role models found that trainees had *equal numbers* of positive and negative role models⁹. But the literature is strangely silent when it comes to faculty role modeling that directly addresses where and how we stand in the face of unprofessional attitudes exhibited by our own colleagues, other than quietly addressing them behind closed doors with students, sighing along with them that 'yes, we know they're out there and you just have to ignore them and not let them get to you.'



Derogatory humor in medicine is an issue I am increasingly being made aware of

as I take my first few steps into the world of clinical medicine. It has been a focus of

many discussions because of its increasing existence or perhaps merely just the increasing realization of its existence. And yet, despite the recurring discussions

about its inappropriateness, there seems to be little, if any, modifications made to

the 'tradition'(which it sadly seems to have become over the years). It scares me to think that these physicians were once in my shoes and maybe had the same thoughts as I do, but then someday when I reach their position, is this how I will evolve?

Does our silence on these issues—the silence we role model—encourage the same in our students? Does our silence mean at best that we think it is inappropriate to call out such behaviors in fellow faculty members, at worst that we condone them? Teaching or encouraging particular attitudes and values have always been complicated issues in any educational context. Traditionally, we merely put forth the collective wisdom and ethical principles of medicine and expect students to adopt them uncritically because they represent the sacred precepts of the profession. This represents a theoretical status quo, which ostensibly enables medicine to reproduce itself over and over again as a profession identified with those precepts. Yet this theoretical status quo is not always reflected in environmental norms of behavior, which represent a parallel status quo, a fact that is repeatedly described in the educational literature. Coulehan and Williams' eloquent and often cited article, 'Vanquishing Virtue,' may state this contradiction best: 'North American medical education favors an *explicit* commitment to traditional values of doctoring—empathy, compassion and altruism among them—and a *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest and objectivity'¹⁰ page 598.

There are countless moments each day in teaching hospitals where students question the validity of these tacit values enacted in the behaviors of their teachers, but they do so silently or quietly among themselves. Indeed, silence is practiced with great frequency during medical training, whereby students quickly learn (if they did not already know) to keep their mouths shut in fear of the consequences of challenging their teachers: getting a poor grade; gaining the reputation of being a trouble maker; decreasing the chances of a residency spot in that location; or being ostracized by the team. Sometimes, if they are lucky, students have trusted teachers with whom they can puzzle aloud about the contradictory scenarios they are witnessing, or write about them in classes or seminars devoted to reflective practices. That is, we develop places in the curriculum to honor students' *feelings* about these troubling incongruities in the medical environment but we rarely provide them with the support, encouragement and *skills* to challenge these incongruities.

Such skills may be found in Papadimos and Murray's use of 'fearless speech' in medical education¹¹. They draw from Foucault's¹² thinking on *parrhesia*, from the Greek *παρρησία* meaning literally 'to speak everything' and by extension 'to speak freely' or 'to speak boldly.' Yet, *parrhesia* denotes not only the freedom of speech but the obligation to speak the truth for everyone's benefit, even when such speech puts one at risk. Papadimos and Murray argue medical students must become able citizens who not only possess the critical skills necessary to understand how power/knowledge operates, but they must develop the capacity to expose and to challenge this power, when required—to speak out fearlessly on behalf of their patients, their profession, themselves and society in general . . . In sum, medical students must learn to practice *parrhesia*, they must speak fearlessly. This does not exactly mean that they will speak without fear; rather, it means that they will learn to have the courage to speak under fearful circumstances—to



address and to critique those institutions or individuals who control more power, knowledge, and technology Such an attitude, behavior or value cannot exactly be 'taught' as a skill or as a piece of positive knowledge. It calls for an apprenticeship by mentors who will foster such an ethos in their students, who demonstrate *parrhesia* themselves, and who actively encourage new discourses in their teaching, their research, and beyond¹¹.

Traditionally many people in the clinical environment, particularly those with the most power and authority, have not encouraged *parrhesiastic* speech. It is, quite simply, not a part of the ethos of medical education because no matter how respectfully such speech is offered, it is most often received as a 'deep criticism or critique of the current order of things, for which those in power (the audience) are somehow responsible. It forces those in power to account for themselves and their actions'¹¹. It is almost unthinkable to imagine a medical student offering an ethical critique to the chairperson of obstetrics and gynecology regarding something he has said or done (e.g., a laughing comment about a patient's breasts), yet it is similarly difficult for clinical faculty to do the same to their own colleagues or superiors. For the student, a very real fear of retribution prevents such a challenge, along with a sense of powerlessness and the ultimate futility in such action to change the faculty member's behavior. For the clinical faculty, the unspoken yet routinely practiced code of resigned silence regarding the bad behaviors of their peers and superiors is what often prevents such a challenge from them.

Yet, as teachers we have wider options than our students for challenging the disrespect of patients, abuse of power and all the inequities that occur daily in all clinical settings. We can show courage in our actions by 'imparting parrhesiastic attitudes, behaviors and values in medical students . . . [giving] them the capacity to challenge the status quo, to transform medical education'¹¹. We can foster fearlessness by creating spaces in which students are able to do more than imitate and internalize the negative behavior found in clinical settings, spaces for challenging the legitimacy of these so-called 'norms' that cause them to question their own values as naive and unattainable, or the 'textbook' values of the profession as being totally unattainable in the 'real' world. Most often such 'spaces' are not specific classes, lectures or seminars. Rather, fearlessness, as conceived here, is an orientation to one's work, one's relationships, one's caregiving commitments. It is fostered, encouraged and role modeled; thus, it infuses an environment by individuals who live such values. Case studies and grand rounds may be developed to focus on moments where fearlessness may be enacted. Faculty appointments can be made on such an inclination. Departmental and institutional mission statements can be crafted to include such an orientation. Wherever one finds it, teaching with and for fearlessness unravels the usual conceptions of socialization into the profession whereby a medical student gains identity through role modeling that cancels out difference. The admired senior doctor, in whose image the student wishes to develop, acts as a mirror reflecting back to the student how he or she would like to be. This 'selfsame' framework of identification acts as a powerful magnet for educational activity, where the student refers back to the doctor-educator at the expense of a potentially productive relationship to the patient as 'other'¹³ page 100.

Discussion

The kind of fearlessness we propose is nothing less than a challenge to the existing social order of medical education. At any given moment, the culture where students are initiated into the profession is saturated with the highest ideals of the profession *and* the social norms that utterly contradict them. It is the work of fearless medical educators to recognize these incongruities in their own actions and in others, and to confront them, which would begin to 'debunk the myth that institutions possess autonomous, even ultimate, power over our lives'¹⁴. These pursuits would reveal to students how their professional identities can be shaped through what they witness in the medical environment in both positive and negative ways, and that they have an obligation to name and confront the practices found every day within and outside medical education that diminish the humanity of patients, caregivers and



students themselves. This obligation, however, can be realized only if students have faculty who hold themselves and their colleagues to the same standards expected of students, and who vigorously support students' efforts to live fearlessly as well. Here, according to Bleakley and Bligh, the role of faculty 'shifts from a fount of knowledge who teaches, to a facilitator who centres his or her attention on setting up appropriate learning environments for students' {13: p. 96}. It is a faculty role that does not involve keeping students in line by appeasing the social status quo, which includes silence. It is a role that lets no one off the hook. It is a role that may, at times, have to bite the hand that feeds its power and status. It is a role that forces faculty to account for their attitudes and behaviors, even when such actions carry personal risk. It is, indeed, a fearless way to live in clinical medicine.

Steadily advancing from crawling to walking into my career, I still can't help but notice the irony in the increasingly disparaging attitude of many health care professionals toward the practice of medicine. The more I try to find a reasonable explanation for it, the more I'm made aware of the cynicism that surrounds me. Instead of being at the receiving end of any form of nurturing from the physicians I'm 'supposed' to look up to, I'm conveniently advised to 'wait until I'm in their (attendings'/residents') shoes' because I'm 'too young and inexperienced' to know right from wrong at this time. What good is this experience that they refer to if it takes them away from the respect and clarity in vision they had toward their patients and colleagues when they were in my shoes? How can they be so sure that their perception is accurate? This is not to say I don't understand their defense, i.e. 'it is not us; it is their fault: the frequent flyers, the non-compliant, the drug-seekers, the 90-year-olds with a full code status.' Yet when I walk into a room to see a patient, I am not a student, resident, an attending or any other number of titles that the hierarchy has established and so unnecessarily emphasized, because none of those matter to the patient. What matters is whether I will deliver the care he/she needs with as much sincerity as I promised to when I made the choice to play that part! I should have the freedom to advocate for my patients without the fear of being reprimanded for being the next-to-invisible student in the hierarchy. Is that unreasonable to ask for? I don't believe working to preserve a patient's respect and dignity requires a position of authority. We are all a team, and each one of us has a part to play, a significant one, even if it just politely to remind each other of our priorities in our profession. Our collective priority is to advance the betterment of our patients, moving past our personal differences and the clashing of human ego. The budding generation of young physicians will not have much, if anything, to look up to if we continue to stand witnesses to detracting and unacceptably demeaning behavior toward our fellow colleagues, and more importantly, our patients. After all, what we breed now is what we will have to bear, ultimately, when we are in our patients' shoes!

Summary

Some might read our student's poignant and reflective essay as a rant directed at well-meaning clinical faculty by an overly idealistic and naïve medical student. We read it as a courageous, thoughtful assessment of a system of education that sometimes fails trainees, an assessment we should respectfully accept. Providing students with opportunities to share their thoughts and observations without fear, honoring their voices in the educational arena, offers hope for reshaping the culture of medical education and patient care to one where the values taught in our classrooms are much more consistently enacted wherever patient care is delivered or taught. Such is our work when we teach—and role model—fearlessness.

(Note: Namrata Dhillon is now a resident in internal medicine at Riverside Methodist Hospital in Columbus, Ohio)



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