When I say. . . praxis

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At first glance, our research foci are worlds apart. SN studies what health professionals do in complex practice contexts, informed by critical theories of practice, and SW studies the ways in which power relations and deeply embedded traditions might limit medical school policies and practices.[1] Yet on one fundamental point our work is united: we share an underlying commitment to praxis. When we say *praxis*, we are speaking of the embodiment and enactment of theory in practice, driven by a commitment to improving that practice. Both of our journeys to education science arose from practical experience in fields we were inspired to help improve. And now, as education scientists in applied settings, we are often found offering theoretical and methodological guidance to practitioners who have ideas and goals for change. For these reasons, we wonder if praxis might unite the work of many health professions educators and scientists, and we explore the concept here for your consideration.

DID YOU SAY 'PRACTICE'? NO, WE SAID 'PRAXIS'!

Practice is what people do. For example, in the health professions, practice includes explaining the results of diagnostic tests to patients. When people use the related word 'praxis', they usually mean a marriage of theory and practice. When theory thoughtfully informs practice, praxis is enacted. Importantly, the theory that informs practice is also informed by lessons learned in practice.

Building on this, when *we* say praxis, we mean the fusion of critical theory and social action, realised through critically reflective practice. How 'knowledge' is conceived of is important here. The concept of praxis can be traced back to Aristotle's forms of knowledge:

- *episteme*: universal, scientific truths;
- *techne*: contextually situated technical skills;
- *phronesis*: practical wisdom with an ethical imperative, and
- *praxis*: theory-informed best action in a given situation.

Scientific truths can inform technical skills (e.g. knowledge of anatomy guides the performance of a lumbar puncture). Likewise, practical wisdom can inform praxis, or doing what is best in a given situation.[2] Bridging this theory into professional practice, Aristotle's conceptualisations underlie the popular education theory of *reflective practice*. Reflective practice describes how professionals think within action, think about their practices, learn from their experiences, and continually and deliberately improve their practice.[3]

Yet praxis, as it relates to professional practice, is not just reflective practice. It is *critical* reflective practice, wherein the 'critical' indicates the application of critical theory in the guidance of everyday action.[4,5] Critical reflective practice therefore specifically requires one to attend to power relations and injustices embedded within society, which are otherwise taken for granted. So, for example, on an everyday basis, a clinician who actively seeks to challenge her own societally driven, implicit assumptions about patients is engaging in praxis. At a structural level, a medical school that decides to study and remedy the ways in which admission requirements inadvertently privilege students of particular cultural backgrounds is engaging in praxis.

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IS PRAXIS MISSING FROM HEALTH PROFESSIONS EDUCATION?

Not exactly. We often hear students claim that they come into health care thinking they will help change the world. Through a praxis-based philosophy of education, we wonder if curricular strategies could do more to encourage and enable such goals toward positive change.

Recently, there have been calls to emphasise aspects of health professions education such as advocacy, cultural competence and compassionate care. These initiatives demonstrate an explicit desire and willingness to commit to ethically oriented health professions education. However, praxis-oriented practitioners and scholars would argue that concepts such as cultural competence do not go far enough (and potentially even do damage) toward actually achieving ethical and compassionate care for all.[6] The risk is that through training in cultural competence, learners may merely learn to perform desirable behaviours and use the most acceptable language, without actually changing how they view patients. Praxis scholars instead advocate for a genuine, embodied shift in values and development of personhood in order to enact authentic compassionate care that confronts societally constructed inequities. To accomplish this genuine shift, we must embed praxis into health professions education from the philosophical perspective (such as the medical school vision) through to all aspects of the practical context (such as admissions policies, curriculum planning and assessment strategies).

BUT (HOW) COULD WE ACTUALLY BUILD A PRAXIS-ORIENTED CURRICULUM?

Praxis isn't a discrete skill to be taught in a classroom or tutorial; rather, it is an educational philosophy and moral orientation that aims to move education beyond the 'banking model', whereby facts are deposited into learners.[7] Through praxis, education is positioned instead as a socialising process that moves learners toward *critical consciousness*, a critically reflective 'reading' of the world in which the aim is to see and transform the oppressive social conditions that constrain people.[7] Therefore, a first step in actually building a praxis-oriented curriculum would be to expand the goals of education from the acquisition of knowledge and skill, and performance of professionalism, to include a shift in how one sees one's role in the world in relation to others. For example, through praxis, clinicians would appreciate their privilege and power, and the plight of people in relation to disempowering systems. Moved by this appreciation, clinicians would strive to make positive change.

An example of a praxis-oriented curriculum in medical education is the University of Michigan medical school initiative described by Kumagai and Lypson.[6] In this programme, medical students formed longitudinal relationships with families experiencing chronic illness. Instead of aiming for discussions with students, which would demonstrate their learning about the disease process, the programme was intended to facilitate *dialogue* with both learners and families and hence to create a space for the sharing of emotional learning. Dialogue is underpinned by a commitment to common understanding, which offers transformed perspectives into the doctor–patient relationship. At the end of the year, students represented their experiences in creative ways, sharing imaginative representations of their learning with one another and the local community. These representations gave students opportunities to share their transformed ways of seeing, and others a sense (or assessment) of what was learned.[6]

SOUNDS GREAT. BUT HOW ON EARTH WOULD WE ASSESS LEARNERS?

If the desired outcome of education is a genuine value shift, we need to examine existing assessment methods to determine whether they lend themselves to identifying such a shift. In the Michigan example,[6] the creative representations produced by students serve as evidence of the students' learning; however, this form of assessment would require shifts in how medical schools view assessment and learning.

What we imagine is a curriculum in which a critical and ethical orientation forms the basis for learning. Within a praxis-oriented curriculum, practice-based learning would be valued, fostered with appropriate pedagogy, and modelled by faculty staff. Furthermore, this curriculum would not eschew basic science, technical skills, or the scientifically justified approaches for teaching and assessing them. Rather, we envision all education to occur within a praxis-oriented education philosophy that continually asks if our educational actions are well informed and create positive change, and, if they do not, works toward change.

AND HOW WOULD WE EVALUATE THE SUCCESS OF A PRAXIS-BASED CURRICULUM OR PROGRAMME?

A praxis-oriented curriculum would require a very different approach to curriculum evaluation compared with current models that dominate health professions education (such as competency-based medical education). A successful programme would result in learners who embrace uncertain, unique, unstable, value-conflicted domains of practice as opportunities to make ethically oriented decisions toward change. This sort of outcome is not easily quantifiable through existing (and highly trusted and valued) evaluation methods. Kumagai and Lypson's programme in Michigan[6] was successful in terms of transforming students' perspectives, as evidenced by the creative works of students, and reported impacts on families and community, but it struggled to prove its success by traditional standards. The programme ended when the medical school leadership focused on other priorities. As praxis-oriented scholars, we let this be a powerful reminder to us.

For a praxis-oriented curriculum to be feasible and sustainable, systemic change is required, and a clear justification for praxis-oriented efforts must be made. In terms of systemic change, our field must engage its moral imagination to reconsider priorities and standards, and to shift toward valuing that which cannot be accounted for in a banking model of education. In terms of the justification of efforts committed to praxis, health professions education must imagine and enact a way to value important processes and orientations that it cannot yet measure in appropriately holistic and representative ways. Ultimately, if the health professions wish to uphold their social responsibility, a praxis orientation to education is mandatory.

REFERENCES

1 Wright S. Medical school personal statements: a measure of motivation or proxy for cultural privilege? *Adv Health Sci Educ Theory Pract* 2015;**20** (3):627–43.
2 Flaming D. Using phronesis instead of 'research-based practice' as the guiding light for nursing practice. *Nurs Philos* 2001;**2** (3):251–8.
3 Ng SL, Kinsella EA, Friesen F, Hodges B. Reclaiming a theoretical orientation to reflection in medical education research: a critical narrative review. *Med Educ* 2015;**49** (5):461–75.
4 Brookfield SD. The concept of critically reflective practice. In: Wilson AL, Hayes ER, eds. *Handbook of Adult and Continuing Education*. San Francisco, CA: Jossey-Bass 2000;33–50.
5 Kemmis S. Knowing practice: searching for saliences. *Pedagog Cult Soc* 2005;**13** (3):391–426.
6 Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Acad Med* 2009;**84** (6):782–7.
7 Freire P. *Pedagogy of the Oppressed, 30th Anniversary Edition*. New York, NY: Continuum 2000.

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