On the Way to Reflection: A Conversation on a Country Path

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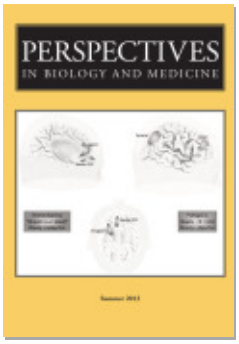

On the Way to Reflection

a conversation on a country path

Arno K. Kumagai

ABSTRACT Ways of exploring the related acts of thinking and reflection are not just confined to expository prose. Following Heidegger's (1966) model of a conversation that gradually reveals deeper meanings of the concept of thinking, the following is a record of a conversation during a walk in the country on a summer's evening. Three individuals, a Doctor, a Philosopher, and a Poet, revisit the topic of reflection from a variety of different perspectives in hopes of understanding its place in the practice of medicine. In particular, they explore an area of reflection where medicine is often silent: during times of great suffering and loss. Along this country path, as night gradually falls, they attempt to capture the complex meanings of reflection that culminate in that intimate "open space" where medicine is practiced and where fundamentally important human events occur.

POET: Let's turn down this path. So . . . where was I? Oh yes. It strikes me that medicine should be *the* field where a poetic imagination might flourish. The constant presence of suffering, pain, loss, birth, struggle, and death—these all-too-human experiences and events—requires a poet's grasp of language and understanding. Sure, there's Keats and Chekov and Maugham, the Japanese novelist Ogai, and Williams, and even the dark, apocalyptic Céline, who were all doctor-writers; but why is it that in human terms, doctors' usual ways of thinking can appear to be so . . . impoverished?

DOCTOR: What? That's not true. Absolutely not. The generation of a differential diagnosis requires tremendously complex thought processes. One must

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have the proper knowledge of physical states; the skills to distinguish abnormal from normal; and the understanding of what tests to order, what procedures to use, what certainty (or lack of) to believe that a specific condition is present or a specific outcome is possible. These processes involve comprehension, application, analysis, synthesis, evaluation . . .

PHILOSOPHER: . . . and can all be done in a locked room.

DOCTOR: What do you mean?

PHILOSOPHER: The processes you're describing are solitary exercises in thinking. They can be done by one person in a room by him- or herself. It's what we'd call in philosophy "monological," the generation of meaning as a solitary activity of reflection, as opposed to "dialogical" thinking, which involves the input of more than one person—working in dialogue—in the construction of meaning (Habermas 1971, p. 137–39).

DOCTOR: So . . . is monological thinking such a bad thing?

PHILOSOPHER: No, not necessarily. Think of Descartes. However, if we're talking about the truly human dimensions of illness and medicine, I would argue that at least some of this type of thinking should be dialogical—*between* people—since human beings are essentially social animals.

DOCTOR: But discussion and consensus often *are* involved. Most biomedical knowledge consists of the building up of conceptual frameworks and paradigms by competing scientific interests over time. It involves establishment of validity through scientific experimentation, as well as agreement about what is scientifically acceptable and significant through consensus among peers.

PHILOSOPHER: Yes, I would agree with in all that; however, as I said: in *human terms*, when in the presence of human suffering, the language of medicine is often silent.

POET: And then there's reflection . . .

DOCTOR: Wait, I feel as though my profession is being attacked. What about reflection? Much of what we do and teach in medicine *is* reflection (Mann, Gordon, and MacLeod 2009). When an experiment fails to prove its hypothesis or produces results other than that expected, when I fail to arrive at a correct diagnosis or am stumped in trying to understand what is going on with a patient, I must reflect on my actions. Were my initial assumptions correct? Is my approach appropriate? Does it meet professional standards of care? What do I need to change to clarify the question or the approach? Wouldn't you agree that those are forms of reflection?

PHILOSOPHER: Yes, I would. Those types of reflection involve either instrumental approaches—that is, how does what I do impact the course of some biological or physiological process—or communicative approaches—that is,

how well does what I do fit with what is considered by consensus as "good" or "correct" (Habermas 1971)? Also, both of these approaches involve varying degrees of self-assessment—that is, how can I do something better? I agree that instrumental and communicative approaches, as well as self-assessment, all involve reflection and are essential in practicing medicine, but there's more.

POET: Perhaps it would be helpful to step back for a moment and define our terms (Wear et al. 2012). The term *reflection* implies the showing or "turning back" of one's imagination or attention on oneself. Dewey would say that reflection involves an interrogation of one's experience, particularly in which a state of doubt, hesitation, or perplexity arises and that reflection involves a search for answers to resolve such a state of doubt (Dewey 1910). So, reflection involves a turning back of one's attention on one's actions, thoughts or experiences with the aim of resolving unsettled questions or doubts. Does that make sense?

DOCTOR: Yes. Both of the activities I mentioned would fit under this definition.

PHILOSOPHER: I agree. In fact, according to Schön (1983), the work of an expert, such as an experienced clinician like yourself, involves a process of trying out different hypotheses and learning to adjust his or her approach in response to experience, surprise, puzzlement, confusion, or specific characteristics or demands of a given situation. Schön calls this process "reflection-in-action" and asserts that it's a key component of reflective practice. This reflection-in-action is an application of both instrumental and communicative approaches and embodies self-assessment and reflection.

POET: Yes, but there's more . . .

PHILOSOPHER: Such as?

POET: The definitions you propose, while correct, are still missing something. For instance, I think we can all agree that medicine is practiced in society and that physicians have a social responsibility toward those whom they serve.

PHILOSOPHER and DOCTOR: Yes, of course.

POET: So what if one encounters a situation involving unfairness or injustice related to medical care? What type of reflection would that be?

DOCTOR: I can think of an example from just last week. One of my adult patients has asthma and can't afford the medications it takes for him to keep it under control. Because he works in a local restaurant, he makes too much money to qualify for Medicaid but not enough for health insurance or medications. Thus, he can't control his asthma and ends up in the ER every month or so, which costs him a fortune, and costs the hospital a fortune too.

POET: How does that make you feel?

DOCTOR: Angry. Frustrated. Powerless as hell.

PHILOSOPHER: That type of reflection is based on something that Habermas (1971) would call "critical knowledge." It is a type of reflection on the self and the world that is related to addressing human needs and interests and has an aim of freeing human beings from suffering and oppression. The educational theorist Paulo Freire (1973) would refer to this same phenomenon as "naming the world," that is, using critical awareness to uncover injustice as the basis for action in the world. Yes, I would agree that this is another type of reflection . . .

DOCTOR: . . . which I practice . . .

POET: Yes, but how explicitly? And how well do we *teach* this particular type of critical reflection? How well do we teach doctors to engage in this type of reflection as part of medical practice (Kumagai and Lypson 2009)?

DOCTOR: What do you mean?

POET: What I'm asking is how often do medical schools teach students to critically look at health care in order to identify injustice and act on it? I'm aware that they learn all types of knowledge and skills about science, disease, procedures, and lab tests, and that "critical thinking" is a very popular term thrown about, but what about this type of "critical consciousness" (Burbules and Berk 1999; Freire 1973; Kumagai and Lypson 2009)? Where do they learn about this?

DOCTOR: What you're asking for isn't a subject or a skill, but something else altogether . . .

PHILOSOPHER: . . . an orientation towards self, others, and the world (Kumagai n.d.; Kumagai and Lypson 2009). It reminds me of the concept of *phronesis*, or practical wisdom, that Aristotle describes in the *Nicomachean Ethics*. This is the type of wisdom that an individual exhibits when he lives in society with other individuals and "lives well" (*eudemonia*), that is, he lives and works justly and correctly for the benefit of himself and for humankind (Fuks, Brawer, and Boudreau 2012; Kemmis and Smith 2008; Kinsella and Pitman 2012; Kumagai n.d.; Montgomery 2006; Pellegrino and Thomasma 1993).

DOCTOR: This would be another way of defining professionalism.

PHILOSOPHER: Yes, I suppose; however, in my view *phronesis* is much more than that. At least as commonly defined, the concept of professionalism implies a dichotomy between professional and personal, public and private selves. In other words, one can be a real professional on the job all the while he or she is terribly unethical in private. Phronesis, on the other hand, involves the person as a unified whole, what Heidegger (1962) would call a "Being-in-the-World," and the dichotomy between private and professional, personal and public, belief and action doesn't apply (Kinghorn 2010).

POET: So how does one actually teach this?

DOCTOR: I suppose that's a subject for a whole other conversation. Let's take this path here, since I'm getting concerned we're wandering a bit off track. So far, we have covered at least three types of reflection: *instrumental*, which is used to understand and intervene in processes—biological and otherwise; *communicative*, which may be used to build consensus on issues or practices; and *critical*, which is used to understand self and others and act on injustice in the world (Habermas 1971; Kumagai n.d.). To varying degrees, self-reflection and assessment is a part of all three . . .

PHILOSOPHER: . . . and we have a physician, who is a social being among other social beings, who practices with phronesis by acting justly and correctly to the benefit of herself and of humans in general.

POET: But something's still missing here . . .

DOCTOR: What's that?

POET: The doctor's actual interaction with the patient. What we've spoken of up until now is how the physician reflects on or acts in the world. What is the patient's role in this interaction? What I mean to say when I say something's still missing is that the presence of suffering, loss, and death, as well as birth, resilience, and recovery, can prompt different types of reflection—both in the patient and in the doctor—and it is precisely here that medicine is so silent.

DOCTOR: I'm still having some difficulty in understanding what you mean.

POET: Great suffering and loss can lead one to "turn back" one's thoughts to oneself and one's life—in other words to reflect, yes?

DOCTOR: Yes, I suppose, if someone is open to that . . .

POET: That's right . . . *if someone is open to that*. I would think that the type of reflection this situation would prompt is neither instrumental nor communicative nor critical, but something different all together. Through empathy, one might tap into someone else's narrative—his or her way of understanding the world—and thus, in times of crisis or loss, one can access this understanding through imagination (Charon 2001; Kleinman 1988; Kumagai 2008). On his deathbed, the great itinerant poet Bashō (2006) said:

> Sick on my journey
> Only my dreams will wander
> These desolate moors

DOCTOR: There are deaths that I've witnessed, times when my inability to cure or even to measurably decrease suffering have haunted me.

PHILOSOPHER: So what will we call this type of reflection?

POET: How about "lyrical?"

PHILOSOPHER: Sounds apt. Other types?

POET: Since I brought up Bashō, another type of reflection that occurs to me is a type of *mindfulness* (Epstein 1999).

PHILOSOPHER: How is that a different type of thinking or reflection?

POET: Actually, it's a type of reflection that involves an absence of thought.

DOCTOR: How's that?

POET: In Zen terms, it's called *mushin no shin*, or "mind of no mind," and involves a suspension of thought in order to be fully present in the moment (Suzuki 1988). A classic example of this practice is the Japanese tea ceremony, in which each of the rituals represents a separation of the participants from the world outside in order to fully engage in a fleeting moment of calm reflection. The image here is of a perfectly calm pond in which the moon is fully reflected on its surface. No thoughts are present to disturb the reflection, as would pebbles thrown in the pond.

PHILOSOPHER: But how would this apply to medicine?

DOCTOR: I think that I can answer that. When all else has failed, when nothing more can be done,when there are no procedures or machines or "magic bullets" left, there is only being present, *being with*, showing concern.

POET: Life in this world
is brief as time spent sheltered
from winter storms (Sogi 2006)

DOCTOR: So where to now?

PHILOSOPHER: I think I know. Let's go this way. . . . There's one more form of reflection that may apply here. In these situations in which a physician *bears witness* to suffering and death, there is, for lack of a better term, a sort of "existential reflection."

POET: Explain.

PHILOSOPHER: In times like these, when one is fully present and bears witness, one is at the moment of fully understanding what it means to be human.

POET: And by "understanding," we don't just mean cognitively grasping something . . .

PHILOSOPHER: No. Something much more . . . something like a deep and abiding engagement in, or connection to, what it means to be human (Heidegger 1962; Kumagai n.d.).

Two ideas might be helpful here. According to Gadamer (1975), each individual possesses a *horizon*, a specific way of looking at the world based on individual identity and history, perspectives and values, and lived experiences. Interactions between individuals therefore involve acts of interpretation, in which each attempts to interpret the other in terms of his or her own

perspective; these interactions thus become a fusion of horizons, in which individual perspectives combine such that the resulting worldview is greater, richer (Kumagai 2012).

POET: What you seem to be saying is that at these moments, the doctor's and patient's horizons merge in such a way that both might increase their understanding of themselves, each other, and the world.

PHILOSOPHER: Yes, something like that.

DOCTOR: But only if they're *open* to it.

PHILOSOPHER: Agreed . . . which brings me to my next point. Heidegger (1962, 1971) speaks of "the Open" or "the clearing," in which Being is fully realized in all of its mystery and relationship to the world. I think that at moments of great suffering or loss, this "clearing" is revealed: a time and place where individuals are in the act of becoming, of creating themselves anew . . . and perhaps, in the intimacy of the moment, the full richness and wonder of human beings and their experiences, the core of who we all are, can be accessed by the physician. This very human knowledge can go deep within the physician, so that, in Polanyi's (1966) words, it "comes to dwell within us" (p. 16). That is, it becomes part of our core selves and part of how we see and act in the world.

DOCTOR: So, how do we translate this to daily living in the world?

PHILOSOPHER: Heidegger (1966) would say that this approach is embodied in meditative thinking. It's a type of thinking where we slow down our pace and allow an "openness to the mystery" of Being. In contrast to what he calls "calculative thinking," this type of meditation involves waiting *upon* rather than the usual waiting *for*. Instead of waiting for something specific to occur, by waiting upon, we leave ourselves open to mystery, to a deeper meaning of what life and Being have in store for us. So part of all of this reflection in the form of meditative thinking is to slow down our pace in order to approach these moments of communion with a deeper understanding of life, death, struggle, and recovery.

DOCTOR: Look, night is falling . . .

POET: Often, I gazed at you in wonder, stood at the window begun
the day before and gazed at you in wonder. As yet
the new city seemed forbidden to me, and the strange
unpersuadable landscape darkened as though I didn't exist. . . .
(Rilke 1989)

PHILOSOPHER: And across this open field at night, we see lights . . .

DOCTOR: We're almost home.

References

Bashō, M. 2006. Death poem. In *The sound of water: Haiku by Bashō, Buson, Issa, and other poets*. Boston: Shambhala.

Burbules, N. C., and R. Berk. 1999. Critical thinking and critical pedagogy: Relations, differences, and limits. In *Critical theories in education: Changing terrains of knowledge and politics*, ed. T. S. Popkewitz and L. Fendler. New York: Routledge.

Charon, R. 2001. Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA* 286(15):1897–1902. doi: 10.1001/jama.286.15.1897.

Dewey, J. 1910/2005. *How we think*. New York: Barnes & Noble.

Epstein, R. M. 1999. Mindful practice. *JAMA* 282(9):833–9.

Freire, P. 1973. *Pedagogy of the oppressed*, trans. M. B. Ramos. Repr. New York: Continuum, 1993.

Fuks, A., J. Brawer, and J. D. Boudreau. 2012. The foundation of physicianship. *Perspect Biol Med* 55(1):114–26.

Gadamer, H.-G. 1975. *Truth and method* [*Wahrheit und methode*]. New York: Continuum.

Habermas, J. 1971. *Knowledge and human interests*, trans. J. J. Shapiro. Boston: Beacon Press.

Heidegger, M. 1962. *Being and time* [*Sein und zeit*]. New York: Harper.

Heidegger, M. 1966. *Discourse on thinking*. Trans. J. M. Anderson and E. H. Freund. New York: Harper Perennial.

Heidegger, M. 1971. The origins of the work of art. In *Poetry, language, thought*, 17–86. New York: Harper & Row.

Kemmis, S., and T. Smith. 2008. Personal praxis. In *Enabling praxis: Challenges for education*, ed. S. Kemmis and T. Smith, 15–35. Rotterdam: Sense Publications.

Kinghorn, W. A. 2010. Medical education as moral formation: An Aristotelian account of medical professionalsim. *Perspect Biol Med* 53(1):87–105.

Kinsella, E. A., and A. Pitman. 2012. *Phronesis as professional knowledge: Practical wisdom in the professions, professional practice and education; A diversity of voices*. Rotterdam: SensePublishers.

Kleinman, A. 1988. *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Kumagai, A. K. 2008. A conceptual framework for use of illness narratives in medical education. *Acad Med* 83(7):653–58.

Kumagai, A. K. 2012. Perspective: Acts of interpretation: A philosophical approach to using creative arts in medical education. *Acad Med* 87(8):1138–44.

Kumagai, A. K. n.d. From competencies to human interests: Ways of knowing and understanding in medical education. *Acad Med*, in press.

Kumagai, A. K., and M. L. Lypson. 2009. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Acad Med* 84:82–87.

Mann, K., J. Gordon, and A. MacLeod. 2009. Reflection and reflective practice in health professions education: A systematic review. *Adv Health Sci Educ* 14(4):595–621.

Montgomery, K. 2006. *How doctors think: Clinical judgement and the practice of medicine*. New York: Oxford Univ. Press.

Pellegrino, E. D., and D. C. Thomasma. 1993. *The virtues in medical practice*. New York: Oxford Univ. Press.

Polanyi, M. 1966. *The tacit dimension*. Chicago: Univ. of Chicago Press.
Rilke, R. M. 1989. The vast night. In *The selected poetry of Rainer Maria Rilke*, ed. S. Mitchell. New York: Vintage Books.
Schon, D. A. 1983. *The reflective practitioner: How professionals think in action*. New York: Basic Books.
Sogi. 2006. Untitled. In *The sound of water: Haiku by Bashō, Buson, Issa, and other poets*. Boston: Shambhala.
Suzuki, D. T. 1988. *Zen and Japanese culture, Zen Buddhism and Japanese culture*. New York: Tuttle.
Wear, D., et al. 2012. Reflection in/and writing: Pedagogy and practice in medical education. *Acad Med* 87(5):603–9.