

Chapter 2

Sociological Perspectives on Medical Education

2.1 Introduction

The inaugural editorial of the British Journal of Medical Education (now simply 'Medical Education') claimed 'medical education' as "one of the subjects of medicine" (1966, p. 1) and, therefore, a legitimate *medical* specialism. Norman (2011) identifies three distinct generations of medical education researchers it has, for the most part, been conducted by those involved with medical education itself and with a view to improving and developing the pedagogic practices that form the basis of their concern. Such research can be distinguished from the sociology of medical education. Whilst these two endeavours can, and perhaps ideally should, closely inform one another they are often sharply distinct. This is reflected in the fact that whilst medical education was present at the inauguration of medical sociology, in the shape of Becker et al.'s *Boys in White* (1961) and Merton's et al.'s *Student Physician* (1957), little was done to build on this foundation until recently (Jefferys and Elston 1989). Nevertheless the field of medical education research has grown steadily in the intervening decades.

The past 15 years have seen a resurgence of interest and research on medical education from a sociological perspective. There have been a number of doctoral dissertations and associated publications Brosnan (2008, 2009, 2010; Lempp 2004; Luke 2003; Sinclair 1997) and a recent handbook (Brosnan and Turner 2009a). This chapter draws on this research. Given the trend towards configuring the university medical school as independent from biomedical research, the imperative to conduct research, and the prevalence of professional non-clinical medical educators, it is likely that medical education research will continue to increase. Whilst some have expressed concern about the theoretical sophistication of such research this should be understood as a call for the professionalisation of the discipline and for greater level of mutual engagement between 'theoretical' and 'applied' researchers (Albert and Reeves 2010).

Possibly because it offers a sophisticated perspective on social and professional reproduction Bourdieuan social theory is a notable feature of much recent sociological research into medical education. However Robbins (1993) identifies a

weakness in Bourdieuan theory suggesting it often neglects the formal cognitive content of educational activities. Thus the potential for this perspective to connect with research into medical education has not, yet, been fully realised. The influential article by Hafferty and Franks (1994) on the hidden curriculum is an example of how sociological and education perspectives can compliment one another there remains a need for further engagement. Bourdieu's social theory offers significant potential in this regard. As Harker has suggested his "theory of cultural practice develops the notion of reproduction to far higher levels than can be found in any... specifically educational writing. [Nevertheless] Bourdieu himself does not re-address educational issues from this advanced theoretical perspective" (1984, p. 125). This chapter attempts to develop Bourdieuan social theory in the manner required "to re-insert the consideration of course or cognitive content into the [Bourdieuian] analysis of the teaching and learning process" (Robbins 1993, p. 162). To this end I offer the concept of thinking dispositions as something produced by formal medical ethics education and as a conceptual underpinning for the development of a cognitive dimension to habitus.

The habitus is a central concept in Bourdieuan social theory. It is the embodied and habituated dispositions of individual's and the principle resource of their practical abilities. As such the focus for much of the sociological research into medical education is medical socialisation and directly concerned with the development of a professional medical habitus and the associated dispositions. In the next section I offer some further detail on Bourdieu's social theory before reviewing some of the recent, predominantly Bourdieuan, sociological research into medical education. Finally I situate the broadly psychological idea of thinking dispositions in a Bourdieuan context suggesting it can theoretically augment my perspective on the ethical enculturation that attends the development of medical habitus.

2.2 The Social Theory of Pierre Bourdieu

The social theory of Pierre Bourdieu is a theory of practice. Such theories attempt to overcome the dichotomy between structure and agency and so the invidious choice between sociological determinism and individual freewill. They seek to connect social structure and human agency through reconceiving society as the product of the ongoing discursive activity of individuals and groups. This emphasis reflects the metaphor of learning as participation (discussed in [Chap. 1](#)) where education is conceived as a discursive activity, or practice, engaged in by both teachers and students. Bourdieu perspective is particularly well suited to the theorisation of professional reproduction, the main aim of medical education. He emphasises the interaction of the field with the habitus, of the social structure with the individual, of the medical school with medical educators and, more importantly, medical students. Facilitated by habitus it is the practices of individuals that reproduce the field. In turn exposure to the field results in the 'collective enterprise

of inculcation’—the socialization and enculturation of individual’s habitus—and, therefore, the reproduction of practice(s).

As discussed in the previous chapter Bourdieu rejects the term socialisation preferring “the collective enterprise of inculcation” (Bourdieu 1977, p. 17). One motivation for this may have been because socialisation has (or had) a psychological, rather than sociological or anthropological, flavour that Bourdieu would not have found attractive. However his rephrasing also reflects the way in which individuals play a complicit and even active role in their own socialisation. To be socialised is not a passive experience but involves the participation of the individual in particular social contexts. In addition, whilst Bourdieu never really emphasised the cognitive aspect of habitus, practice and social reproduction, the phrase collective enterprise of inculcation can, I have argued, be understood as reflecting the idea of enculturation. I further develop this aspect of Bourdieuan social theory in the final section of this chapter on thinking dispositions.

Bourdieu’s perspective is a sophisticated and extensively articulated theory that encompasses a range of powerful conceptual tools. Individual discussion of most of these concepts can be found in Grenfell (2008) and a comprehensive introduction to ‘reflexive sociology’ in a Bourdieuan frame can be found in Bourdieu and Waquant (1992). Of necessity my discussion is limited and I focus on the concepts of practice, habitus and field with reference to medical practice and education.

2.2.1 Practice, Field, Habitus

As discussed ‘practice’ is a concept conceived, at least in part, in order to overcome the dichotomy of the individual as an unfettered rational actor or as a determined product of social structures. Conceptions of practice reject the notion that human activity is the product of rules. Rather they are improvised on the basis of our embodied senses. Consider the activity of riding a bike. It is conceivable that we could come up with a set of rules for bike riding that would allow us to design and program a robot to perform this activity. However there is no sense in which human beings are following such rules when they ride bikes. Rather through practice (or ‘rehearsal’) we develop a sense of balance and an ability to coordinate activities such as peddling and steering that allows us to perform the task of cycling successfully. Furthermore whilst there might be more obvious and codified ‘rules of the road,’ a highway code that cyclists should follow when negotiating the public highways, these also become embodied. Certainly novice cyclist can learn the rules of the road by rote but the competent cyclist achieves this status through no longer needing to consciously think about the rules and being able to follow them unconsciously.

From the perspective of practice theory social life is sufficed with practices of this sort. Our ability to walk down a crowded street, hold a conversation, negotiate a market-place, create a home, or do our jobs are all practices based on tacit rules

that we may have never consciously learnt and may not, ultimately, be fully expressible in a propositional sense. Rather we have been socialised into a set of social and cultural practices, some of which include stated ‘rules’ and some of which do not. In the context of medical practice we might think of surgery as analogous to riding a bike. Certainly surgery involves a good deal more knowledge than is given in the Highway Code but it is, nevertheless, an embodied skill acquired through extensive practice. Whilst the competent, indeed expert, surgeon will attend a theatre with a plan, or map, of the operation their performance relies on their embodied ability to use a scalpel. The tacit knowledge of the surgeon or the cyclist is replicated across all social practices and is reflected in Schön’s (1984) account of the reflective practice of professionals. The medical doctors ability to diagnose her patients is not due to ‘technical rationality’ or the simple application of her knowledge of the medical sciences to the specific patient but a skillful ability built up through extensive experience and training.

The way in which a surgical operation is organised involves a number of individuals (multiple surgeons, anaesthetists, specialist nurses etc) further indicates that, more often than not, practice is a collective, as well as social, activity. The successful operation involves the coordination of a range of tasks performed by number of individuals. This coordination is itself a form or aspect of the individuals practice. We can talk about a surgical team working together like a well-oiled machine and, furthermore, we can consider how replacing a member of the team will change the dynamics of their collective practice. The interrelated nature of practice indicates the degree to which we it would be misguided to place too much focus on the actions of individuals. Praxeological theories of society attempt to mediate between the individualism of, for example, Rational Action Theories and the holism of classical sociology. In Bourdieuan social theory this results in the concept of the social field having a variable focus and is capable of application to micro, median and macro levels.

In micro perspective the social field is constituted by the concrete interactions and practices of individuals. The surgical theatre is a social field constituted by the interactions of the surgeons, anaesthetists, surgical nurses, the patient’s body and the various technologies used in the task at hand. The doctor-patient interaction is another such social field. Both of these concrete fields take place within the larger median-level social field of the healthcare center or hospital and, again, these are located within the broader macro-level socio-cultural fields of medicine, nursing and healthcare.

Bottero critiques the Bourdieuan conception and use of social fields as being overly focused “on objective field relations rather than (interpersonal) social relationships” (2009, p. 411). She suggests that there is a sense in which Bourdieu is guilty of “bracketing off” the concrete nature of social networks as a feature of social space... [and] the variable interactional properties of that space” (Bottero 2009, p. 404). This is, perhaps, the result of the tendency of sociological research to adopt a median level focus. Even when empirically focused on substantive examples of, say, the medical school sociologists are interested in producing more general accounts of the medical school *sui generis*. Thus the concrete social field

constituted by specific individuals in specific medical schools becomes abstracted. The conceptual medical school is no longer populated by individuals but by structural positions (professors, non-clinical educators, students, administrators etc.). Nevertheless the conceptual medical school remains, in Bourdieuan terms, a field.

Thompson suggests the ‘social field’ can be understood as operating at “four semi-autonomous levels: the field of power, the broad field under consideration, the specific field, and social agents in the field as a field themselves” (2008, p. 79). Thus the conceptual ‘medical school’ of sociological analysis is, in Thompson’s terms, a specific field, whilst the actual medical school populated by particular individuals is a ‘field as a field in itself’. The medical school also exists within a broader, and multiple, conception of social field, these being the field of medicine and/or healthcare as well as the field of the university or ‘higher education.’ The field of power is the most abstract of Bourdieuan social fields and it is constituted by the (inter)relation of fields, i.e. how the medical field, the healthcare field, the higher education field and the political field(s) are structured and interact. Whilst the more abstract social fields are often the focus of socio-analysis we must, recall that whatever our focus “if we are to get a proper grasp on the social world [we must] always maintain concrete interactions, where ‘it all happens’, as an anchor and final point of reference [whilst nevertheless moving] up and down the scale of abstraction” (Crossley and Bottero 2011, p. 116). The perspective articulated here is based on an abstract conception of the UK medical school but, as my focus is on formal educational practices, it keeps in mind that it is specific individuals and their concrete interactions that constitute the medical school and the medical ethics classroom. It is specific individuals who actually teach and learn.

The focus on the actual, and interacting, individual’s located within the specific field of the medical school or, even, a medical ethics classroom, is maintained through my primary concern for habitus and its development. Bourdieu’s habitus is a generative principle of practice embodied in the individual’s dispositions. When combined with a specific social situation (or field) it results in practice. The dispositions of habitus are produced through Bourdieu’s ‘collective enterprise of inculcation,’ the accumulation of experience and an ongoing exposure to the field. As such it is the product of socialisation and, I have suggested, enculturation. Fully formed it entails a practical mastery of the ‘game,’ ‘task’ or ‘practice’ at hand. The metaphor of the game, particularly of sporting games, is one regularly adopted by Bourdieu. Our ability to play games, football or rugby say, is not simply one of knowing and applying the rules but is a matter of our embodied abilities and, furthermore, a practical sense. The football player not only develops skillful abilities with a ball but also a sense of their place in the team and the approach or strategy it takes to playing the game. Relative to their position players have a practical sense of the range of possibilities the field presents. Spectators often develop a similar, but nevertheless different, sense of the possibilities and can, thereby, appreciate (or depreciate) the tactics a team adopts when playing.

This sense of the game and associated ability to perceive the range of possibilities the field presents is produced by the habitus. It should be understood “as a

system of dispositions, that is of permanent manners of being, seeing, acting, and *thinking*. Or a system of long-lasting (rather than permanent) schemes or schemata or structures of perception, conception and action” (Bourdieu 2002, pp. 27–28, emphasis added). Some have considered it a deterministic concept (Jenkins 1982) however, consistent with Bourdieu’s suggestion that “habitus offers the only form of durable freedom, that given by the mastery of an art, whatever the art” (Bourdieu 1999a, p. 340), Robbins thinks it a form of soft determinism (2012, p. 31) whilst Meisenhelder (2006) likens it to the role of character in earlier social theory. The habitus of medical professionals inculcates within them a set of dispositions which condition their ‘manners of being, seeing, acting, and thinking’; it results in their medical gaze and an ability to diagnose patients given the range of possibilities. We can see then that the medical habitus does not determine the diagnosis but, rather, offers the only form of professional freedom, the mastery of the art (and science) of medical practice.

As discussed in more detail in the next section, the medical habitus is produced through the process of medical education, a process that includes aspects of formal education and what we might call an apprenticeship. Through exposure to field of practice the dispositions of individual medical students are altered, developed and restructured to meet the needs of future medical practice. Medical students come to take on the bearing of a Doctor and the ability to see, act, think and practice as one. The development of habitus is an unconscious process but, nevertheless, one which has important conscious effects. In his earlier writings the cognitive aspect of Bourdieu’s use of habitus had greater clarity (Lizardo 2004; Maton 2008, p. 57) and one might suggest this made something of a return in his later writing (Bourdieu 1999b, 2000, 2004). Nevertheless most interpreters highlight the non-cognitive aspect of habitus and, therefore, of practice. In the next section I present an overview of some recent Bourdieuan research into medical education before turning to the psychological idea of ‘thinking dispositions’ to provide a basis to understand habitus as a generative principle of the obviously cognitive practice and pedagogy of professional medical ethics.

2.3 Critical Sociologies of Medical Education

2.3.1 Medical Education Research

Sociological studies of medical education tend to be understood as part of medical sociology. However they also relate to another substantive area of sociological enquiry, the sociology of the professions. For our purposes it is interesting to recall that “if one thing is thought to characterise a profession besides knowledge it is a code of ethics: professionals are people who act ethically and therefore questions of value are the essence of professional practice” (MacDonald 1995, p. 167). However the sociology of the professions often adopts an approach that I earlier

termed “irony as methodology” (Anderson and Sharrock 1983). Studies conducted in this mode tend to expose ‘moral reversals’ which turn the bad into the good or the good into the bad. Such studies tend to undermine or criticise the official discourse to reveal the operation of power, unacknowledged influences and alternative explanations. In this view ‘ethics’ is often seen as part of the institutional apparatus used by professions to protect their autonomy. Whilst it is certainly the case that the sociological of medical education also has a critical aspect that undermines the discourse of the profession it is nevertheless also the case that it can, and often does, make a positive contribution. Sociological research on medical education offers a more comprehensive understanding of professional reproduction and, particularly, the process of professional socialisation. In so doing the aim is to make a positive contribution to future developments in medical education whether this be in pedagogical terms, in terms of producing better, more ‘humanist,’ doctors or in regards addressing structural inequalities in terms of class, gender or race.

Whilst there has been relatively little sustained attention paid to the topic since Merton et al.’s *Boys in White* (1957) and Becker et al.’s *Student Physician* (1957) there has been recent surge of interest in the area. Whilst some interest was evident in the 1980s (cf: Atkinson 1981 and Colombotos 1988) it was not until the late 1990s the contemporary range of sociological activity in medical education began. Perhaps the pivotal article was Hafferty and Frank’s ‘The hidden curriculum, ethics teaching, and the structure of medical education’ (1994). So influential is the perspective they articulate that the hidden curriculum can now be considered not simply an analytic perspective on medical education but a theory of medical education (Hafferty and Castellani 2009). However the development of sociological perspectives on medical education cannot be credited with responsibility for medical education’s contemporary self-understanding. The success of Hafferty and Frank’s message must also be considered as a function of changes in the field of medical education, changes that are discussed in the next chapter.

Hafferty and Franks conception of the hidden curriculum seeks to express the fact that assumptions surrounding the informal and formal curriculum, the medical student’s accumulation of experience through clinical placements and their classroom-based education, exist in tension. Indeed the informal moral socialisation of medical students that occurs in the clinical context is often presented as a justification for formal ethics education and, latterly, the education in medical humanities. They are understood to offer a humanistic corrective to the techno-scientific excesses of modern medicine that can act to obscure and even dehumanise the individual patient. Whilst Hafferty and Franks highlight the potential for conflict between the morally socialising informal curriculum and the ethical education offered as part of the formal curriculum they offer a deeper analysis concerning the hidden curriculum, defined as “a set of influences that function at the level of organisational structure and culture” (Hafferty 1998, p. 404). The hidden curriculum is presented a major contributor to medical student’s socialisation.

As the focus here is primarily on connecting the formal pedagogy of ethics education and the informal moral socialisation of medical students the hidden curriculum is only indirectly addressed. My use of the term enculturation seeks to provide a way to overcome the disconnect between our understanding of the process through which the formal and informal curriculum contributes to the professional reproduction of medical students whilst leaving intact the potential for their content to be in conflict. However, the hidden curriculum should not be considered merely an aspect of medical education's informal curriculum but as also present in medicine's formal curriculum. Once the formal and informal aspects of medical education have been theoretically connected a more constructive and comprehensive analysis of the underlying hidden curriculum should result from further research using this renewed perspective on professional reproduction.

2.3.2 Bourdieuan Studies in Medical Education

Whilst a range of theoretical approaches has been adopted in sociological studies of medical education it is nevertheless the case that Bourdieuan perspectives have predominated. Bourdieuan social theory has been called a "guiding framework" (Brosnan and Turner 2009b, p. 4) for the sociological study of medical education and one that "is primed to examine" Brosnan (2009, p. 60) a range of contemporary questions. Furthermore as a relational sociology it is well placed to overcome the autonomous subsets found within the sociology of medical education that, variously, focus upon and neglect the socialisation of medical students and the structural aspects inherent in the social organisation of medicine and medical education (Hafferty 2000).

Brosnan and Lempp both demonstrate that medical students are required to conform to the structural demands of medical education and, therefore, of the profession. Consistent with the above these demands may be formal, informal or hidden. There are the explicitly recognised requirements of medical education, such as a certain knowledge base, the passing of exams, and a range of informal expectations, conventions and norms. But, as Lempp has demonstrated (2009, p. 79), there is also an requirement to conform to a range of hidden imperatives if the game of medical school is to be played successfully. This indicates the range of inputs that contribute to the formation and reproduction of the medical habitus, something more directly addressed in the work of Sinclair (1997) and Luke (2003).

2.3.3 Developing the Medical Habitus

Brosnan suggests that the "habitus is essentially Bourdieu's theory of socialisation" (2009, p. 56) and, given its intimate connection with the concept of the field

and, therefore, social structure it offers a ground for connecting these disparate aspects of the sociology of medical education. In Bourdieuan terms then the socialisation of medical student is a process which develops and (re)structures their habitus through exposure to the broader institutional and organisational culture(s) of medicine. Brosnan's major concern is to articulate the connection between student socialisation and the way in which the profession structures medical knowledge. There is a dichotomy between the art and the science of medical practice and, in her study of 'traditional' and 'innovative' medical education, this (re)emerges as a dichotomy between scientific knowledge and clinical experience with the more humanistic aspects of medical education and knowledge being neglected in both contexts.

In her study of medical education as involving a transition from medical student to pre-registration doctor Lempp (2004, 2009) makes use of Bourdieu's idea of a 'feel for the game'. The idea of social practices as being part of a 'game' is a recurring motif of Bourdieu's work and he often metaphorically compares social life to sport. Differently located individuals struggle for recognition and compete for resources that, in Bourdieu's terms, are understood to be forms of capital (Moore 2008). However, in this context, we can draw a distinction between mastering the practice of medicine, and so 'being a medical professional,' and mastering the game of medical education, and so 'being a medical student.' To varying degrees students arrive at medical school pre-equipped to master the game they are being asked to play. The entry requirements are not simply about grades but also about what kind of person the student is. These two factors are not unrelated, achieving certain grades in certain subjects has some relevance to character. Considering the social context in which this achievement was accomplished can give offer further insights. As Brosnan suggests (2009, p. 61) differing medical schools look for and attract different sorts of applicants. This indicates that the habitus of (future) medical students and professionals is preconditioned by their trajectory through the fields of education and society more generally.¹

As this indicates we can consider medical professionals, clinical and non-clinical educators, and medical students to embody differing habitus all of which can be implicated in the pedagogical practices of medical education. As such we might consider medical education less a game than a choreographed dance; less a competitive sport, although certainly there are still competitive aspects, and more a cooperative performance. Within the choreography of this performance there remains room for improvisation; pedagogical practices vary between medical schools both in their general typology, i.e. whether they have a Traditional, Integrated and Problem-Based Learning (PBL) curriculum, and in the details of the curriculum and its organisation. Nevertheless there is clearly a repetitive and programmatic aspect to medical education and training. There is a path laid out for

¹ It is also interesting to note that whilst there have been significant changes to the demography of medical students in terms of gender and ethnicity over the past four decades there has been little change in terms of their social class (Lempp 2009, p. 73).

students to follow. Some dimensions of this path are explicit and some are not, nevertheless the student must learn to negotiate it if they are to reach the end.

In Bourdieuan terms the ‘path’ medical students are asked to negotiate is a structured trajectory through the particular social field of medical education. Traversing this path involves the adaptation and transformation of medical student’s preexisting habitus (Luke 2003, p. 65) and, as a result, the (re)production and development of a specifically medical habitus. In her study of Australian ‘Housemen’—post qualification but pre-full registration junior doctors—Luke prefers to think in terms of professional development rather than socialisation (2003, p. 49). As with my use of the term enculturation her concern is to avoid an ‘over-socialised’ picture of medical education. However whilst it is legitimate to suggest that, in her study, the medical habitus is fully and empirically present this is not the case in my own. There may still be significant professional development required of Housemen before they can practice independently but, nevertheless, they are engaged in practice in a way that undergraduate medical students are not. In the context of the professionally qualifying degree it is better to restrict oneself to the term socialisation (and enculturation) rather than professional development, as we must consider the acquisition of the professional medical habitus, rather than its further development, the basic teleos of such education. However, we might note that all fall under the rubric of the collective enterprise of inculcation and professional reproduction.

Thus, in a Bourdieuan perspective, the implicit purpose of medical education is the (re)production of the medical habitus. The medical habitus is structurally presented to medical students in formal pedagogy, informal experiences and through role models. Whilst the medical habitus is embodied in many of the medical student’s teachers it is important to realise that it is the experience of being taught, the exposure to medical education’s various curriculums, and their acclimatisation to the culture(s) of medicine (particularly the medical school and the teaching hospitals) that results in medical student’s internalisation of the social and cultural structures of medicine in the form of a specifically medical habitus. Such an understanding reflects Bourdieu’s conception of the (medical) habitus as “structured structures predisposed to functions as structuring structures, that is, as principles of the generation and structuring of practices and representations” (Bourdieu 1977, p. 72) and the way in which it is intertwined with the (medical) field, a connection forged through practice (a concept which includes ‘rehearsal,’ legitimate peripheral participation and apprenticeship i.e. the practice of being a medical student).

In his ethnographic study of medical education ‘Making Doctors’, Sinclair (1997) attempts to construct an account of the medical habitus or, more accurately, its dispositions. He combines a Bourdieuan approach with the seminal research of Merton et al. who considered socialisation to refer “to the processes through which [the medical student] develops his [sic] professional self with its characteristic values, attitudes, knowledge, and skills, fusing these into a more or less consistent set of dispositions which govern his behaviour in a wide variety of professional (and extra-professional) situations” (Merton 1957, p. 287). As the habitus is

considered to be “systems of durable transposable dispositions” (Bourdieu 1992, p. 53) there is a *prima facie* compatibility with this earlier ‘dispositional’ perspective.

Sinclair identifies eight dispositions: Competition; Co-operation; Economy; Experience; Idealism; Knowledge; Responsibility; and Status. Sinclair consider Knowledge, Experience and Responsibility to be the primary dispositions of the medical habitus and, given the importance of all three to professional medical practice based on specialisms largely determined by the biomedical sciences, we can see why this might be. Whilst Sinclair’s dispositions are a useful characterisation of the medical habitus they only provide a general indication of the practice(s) they are supposed to underpin. As my project here is more tightly focused on medical ethics education and, therefore, on the practice of medical ethics greater specificity regarding the dispositions being enculturated is required. Given the nature of contemporary medical ethics as form of applied philosophy—a cognitive practice—this specification requires, first, a recognition of the cognitive aspects of habitus and, second, the appropriation of the psychological concept of ‘thinking dispositions.’

2.4 The Cognitive (Medical) Habitus Needs (Ethical) Thinking Dispositions

That Bourdieu offers a way to properly recognise the unconscious aspects of our social practices is central to the power of his social theory. However we must also recognise that many of our practices have a cognitive dimension. At minimum Bourdieu tends to underemphasised the cognitive aspects of practice. Nevertheless within a Bourdieuan perspective there are strong reasons to acknowledge that communication and reflection are a necessary aspect of acquiring even the most embodied forms of practice (Nobel and Watkins 2003). To suggest that certain of our practices are cognitive is not to suggest that they are asocial or that they occur in a decontextualised or acultural manner. The practice of ethics, or of ethical reflection, is an aspect of modern medical practice and so it is an example of the social and cultural nature of our cognitive practices. Whatever one thinks of the philosophical foundations of medical ethics, or of morality and ethics more generally, one must recognise that, if it is to be practiced, the culture of medicine is central to the nature of contemporary medical ethics, and vice versa. Any philosophical medical ethics must be instantiated within medical culture. As such professionals medical ethics is a ‘way of thinking’ consistent with ‘how doctors think’ (Montgomery 2005) more generally. We might also point to the relevance of the way medicine constructs its objects (Good 1993, Chap. 3) and, particularly, the language of case presentation (Anspach 1988) for the discourse of medical ethics.

The primary characteristic of contemporary medical ethics is, perhaps, its cognitive or reflective nature. Prior to the emergence of bioethics the ethical

practice of medicine was considered to be largely intuitive and a function of the kind of (gentle)men, and it was broadly men, that doctors were. It is perhaps best summed up by an undated quotation that prefaces the IME's Pond Report. Attributed to 'A Doctor' it reads: "One is ethical—I mean, for heaven's sake—is one not?" (Pond 1987, Preface citation). Until relatively recently it was assumed that medical professionals would simply know what the right thing to do was and, furthermore, could be unquestionably relied upon to do it. As discussed in the following chapters the emergence of reflection in medical ethics was accompanied, if not preceded, by the emergence of reflection across other aspects of the medical curriculum and, indeed, by the very idea of the professional as a reflective practitioner (Schön 1984). The 'reflective' nature of modern medical ethics is not simply a function of external applied (bio)ethical discourses but echoes other developments in the culture of medicine and medical education. As such medical ethics can be considered as one aspect of the broader medical habitus of the reflective professional.

It can seem odd to consider 'reflection' as an aspect of habitus. As Brubaker points out such a perspective implies that there are "unreflective dispositions to reflect" (1993, p. 225) suggesting that, in the relevant contexts, those with such dispositions automatically engage in reflection. Furthermore we reflect and act on our beliefs, something that modern theorists such as Ryle have characterised as dispositional (Price 1969, p. 243 see also Schwitzgebel 2002). Stueber (2005) has sought to explore the notion of dispositions in the context of following rules and, therefore, beliefs. His analysis differentiates between first and second order dispositions. The former involve the production of regular behaviour and can include reflective activity whilst the latter produce reflective activity that monitors and can affect current and future behaviour. Schön proposes that reflective practice is an essential aspect of what professionals do whilst Bourdieu considers reflexivity to be a (normative) aspect of sociological habitus. Thus we should consider reflection and reflexivity to be supported by the relevant dispositions and, in the latter case, predicated on the sociologist's social scientific habitus (Bourdieu 2004, p. 89). The conclusion that the cognitive activities of researchers and professionals are underpinned by the thinking dispositions of the cognitive habitus is unavoidable.

The idea of 'thinking dispositions' is prevalent in the more psychological strands of education and philosophy but has not made any real impact in sociology, including cognitive sociology. One might question whether it is valid to adopt this predominantly 'psychological' concept under a broadly sociological rubric. The answer turns on what, precisely, is meant by a disposition, something Bourdieu did not discuss extensively. He presents his use of the term disposition as being in the interests of provoking "a more concrete intuition of what habitus is and to remind you what is at stake in the use of such a concept, namely a peculiar philosophy of action, or better, of practice, sometimes characterised as *dispositional*" (Bourdieu 2002, pp. 27–28). In a widely cited footnote he suggests that:

"The word disposition seems particularly suited to express what is covered by the concept of habitus (defined as a system of dispositions). It expresses first the result of an organising action, with meaning close to that of words such as structure; it also designates a way of

being, a habitual state (especially that of the body) and, in particular, a predisposition, tendency, propensity, or inclination. [The semantic cluster of ‘disposition’ is rather wider in French than in English, but as this note—translated literally—shows, the equivalence is adequate. Translator.]” (Bourdieu 1977, p. 214, fn1).

Interestingly this exact phrasing—a tendency, propensity, or inclination—has been used to characterise thinking dispositions; they are “a tendency, propensity, or inclination, to think in certain ways under certain circumstances” (Siegel 1999, p. 209). Whilst there is a *prima facie* affinity between Bourdieu’s social theory and this idea of thinking dispositions we might still be concerned that this offers a deterministic picture of human agency, a charge often leveled at Bourdieu and ‘dispositionalism’ (Lahire 2010, pp. 50–56). However consistent with Swartz’s suggestion that Bourdieu’s “[a]ctors are not rule followers or norm obeyers but strategic improvisers who respond dispositionally to the opportunities and constraints offered by various situations” (Schwartz 1997, p. 100) Siegel suggests that thinking dispositions cannot legitimately be thought of as deterministic, concluding “that thinking dispositions are not reducible to either formal rules of thought or to particular behaviours or patterns of behaviour” (Siegel 1999, p. 214).

The conceptualisation of thinking dispositions has an affinity with the idea of enculturation and with the acquisition/participation metaphors of learning. Tishman and Andrade suggest they “are learned through a process of enculturation rather than direct transmission. Thinking dispositions... are characterological in nature, and, like many human character traits, they develop in response to immersion in a particular cultural milieu” (1996, p. 9). Thinking dispositions are not just one thing, there is no singular way of thinking well. Instead the concept of thinking dispositions reveals that we should consider there to be better and worse ‘ways of thinking’ in particular situations or fields. Thus we might, again, distinguish between not only better and worse ethical thinking but better and worse ethical thinking in the cultural milieu of professional medical practice as compared to the field of applied philosophy or ‘academic bioethics’. Thus whilst Perkins et al. (1993) identify seven ideal thinking dispositions there is a need to give further specification *propos* the cultural milieu of medical ethics education and, implicitly, medical ethical practice.² In what follows I take each in turn and consider its relevance for professional medical ethical thinking and the medical ethics education that aims to foster them.

² It is interesting to note that Ennis (1996) offers a set of 14 thinking dispositions that are more detailed and less generalised than those discussed here. Furthermore Tishman and Andrade (1996), p. 5 compare thinking dispositions to Costa’s (1991) five ‘passions of mind,’ these being Efficacy, Flexibility, Craftsmanship, Consciousness, and Inter-dependence. In my view these are reminiscent of Sinclair’s (1997) use of the concept of dispositions.

2.4.1 The Disposition to Be Broad and Adventurous

A thinking disposition to be broad and adventurous is unlikely to be a central medical or ethical thinking disposition. In a reasonably strong sense medical education, socialisation and enculturation is aimed at reproduction, i.e. the production of conformity. Whilst medical students testing medical knowledge on themselves (Sinclair 1997) is indicative of a certain sort of adventurousness and a broad or ‘generalist’ thinking disposition may well be required of those who intend to go into General Practice. Nevertheless it is the case that medical professionals should be morally and epistemically interchangeable. In the case of both medical diagnosis and ethical judgement it is conformity, not adventurousness, that is of primary value in practice.

2.4.2 The Disposition Toward Sustained Intellectual Curiosity

Undergraduate medical education is only the first step in a career that now involves continuing professional development. In this sense the medical habitus must include a disposition towards sustained intellectual curiosity. However, this disposition may only variably apply to medical ethics. Medical practice demands a practical disposition and a certain level of ethical intellectualism is not consistent with the imperative to act. Whilst there is increasing opportunities for medical students and professionals to pursue their intellectual curiosity as with other areas of medicine there is an ethical division of labour. Those whose curiosity extends to ethics can pursue this interest and, in doing so, make a distinctive contribution to the profession. In particular we might highlight the contribution they might make to the institutionalised ethical discourse of this self-governing profession. However there is a point at which developing a disposition towards sustained intellectual curiosity obstructs the production of practicing professionals. Thus its development in the context of undergraduate medical education might be delimited or highly directed.

2.4.3 The Disposition to Clarify and Seek Understanding

Seeking clarity and understanding is central to the medical habitus. A doctor must, for example, clarify symptoms with patients and make sure they properly understand what is being communicated. An applied philosophical view of medical ethics indicates that this disposition is likely to produce a concern for the definition of ethical concepts and their appropriate application to (generalised) cases. This disposition motivates discussion and reflection on the ethical issues of medicine and the identification, resolution or accommodation of disagreement. However one

might be concerned that, within the medical habitus, clarity and understanding is sought in such a way that patient's individuality can be obscured. An overly abstract view of medical ethics is common. Nevertheless, suitable orientated, this disposition can provide a link to the affective and emotional aspects of medical ethics and the doctor-patient relationship.

2.4.4 The Disposition to Be Planful and Strategic

Certainly the medical habitus must include a disposition to strategically plan the care of patient(s), particularly in the context of multi-professional teams. In the case of medical ethics this is perhaps best represented by prospective discussions of Do Not Attempt Resuscitation (DNAR) orders. This can be considered in relation to specific patients but also in terms of wider biomedical discourses. There has been a recent trend towards questioning the presentation of resuscitation in medical dramas in order to counter the public's assumptions regarding the success rates of the procedure. Encouraging the patients to consider their wishes in a range of circumstances, particularly with regard to organ donation, is another aspect of the strategic planning of medical ethics. The prospective discussion of ethical principles during medical education, and the formation of professional ethical guidance by the GMC, the BMA etc. is also an example of this disposition.

2.4.5 The Disposition to Be Intellectually Careful

One can see the enculturation of a disposition to be intellectually careful in the idea of medical education as involving training for uncertainty (Fox 1957) and certainty (Atkinson 1984). The uncertainty of medical practice is often hidden from patients who can often be presented with certainties that are, nevertheless, inherently probabilistic and concern the management of risks. Care is taken not to unnecessarily concern patients whilst also not misleading them. The range of possible diagnosis of a set of symptoms or a proposed test might only be alluded to. Modern medical ethics is often construed as theoretically requiring full disclosure however a more nuanced, or intellectually careful, understanding reveals it requires a sensitivity to the patient and the circumstances, including the medical and the social circumstances. We might note that this disposition should, as with the medical habitus more generally, be understood as being fundamentally conditioned by the practical, rather than theoretical, dimensions of both scientific and ethical practice.

2.4.6 The Disposition to Seek and Evaluate Reasons

The imperative to seek and evaluate reasons is certainly an aspect of a medical ethical thinking disposition. However, in a strong sense medical ethics education is not about teaching medical students solve ethical dilemmas as much as it is about teaching them to have reasons for their actions. This is a subtle and, over time, somewhat blurred distinction. Medicine, and particularly certain of the medical specialisms, have characteristic ethical problems and associated ‘solutions’ or responses. Thus the ethics of medicine involves stock reasons that are ‘pre-evaluated’ both in the sense that they are institutionalised in codes or guidance or through repetition in practice. In the case of ethics this disposition may not always be fully exercised in response to characteristic cases but may come to the fore when cases deviate in ethically important ways. Furthermore it is obviously relevant to the ongoing ethical discourses of the profession and its interlocutors where the characteristic case, its deviations and the reasoned responses of medical professionals are more fully discussed.

2.4.7 The Disposition to Be Metacognitive

It is certainly the case that a metacognitive disposition or, perhaps, what Schön (1984) would call reflection-on-action is central to medical education and practice. However, as discussed in [Chap. 1](#), what metacognition denotes varies across differing disciplines, notably (analytic) philosophy and theories of (professional) practice. For the purposes of this book metacognition can be considered reflection that involves relating abstract concepts and concrete circumstances in a dialogical and goal related context. Thus, in practice, this metacognitive disposition involves ethically discussing cases in terms of the abstract concepts and principles of medical ethics. In characteristic cases this may be a relatively simple task but in more unusual or complex cases this may involve more extensive reflection and analysis. It is also central to the broader professional discourse on ethics and its codification and official guidance.

2.5 Conclusion

In this chapter I have offered a brief introduction to Bourdieuan social theory and an overview of some recent research into medical education that has been conducted under its rubric. I have argued that if we are to adequately understand the ethical enculturation of medical students, as well as their moral socialisation, then we must develop a more cognitive perspective on habitus ideally with reference to the idea of thinking dispositions. It is evident that the professional practice of

medical ethics is a cognitive and reflective activity but that it differs from the academic practice of applied ethics. As such we should recognise that primarily normative aspect of bioethics does not lie in the any ‘solutions’ to ethical questions it may offer but in regards the way ethics ought to be done. In the course of medical practice these prescriptions can only be partially fulfilled and the insights of applied ethics as an academic discipline must be culturally reappropriated into the professional medicine context(s). Although it is perhaps not always fully recognised academic bioethicists can and do make a contribution to this cultural reappropriation.

This reappropriation results in a renewed, similarly normative, framework for ‘doing’ medical ethics. I have presented this framework in terms of thinking dispositions and it should be recognised that these are an idealisation of what happens in medical practice. As such, in the context of research such as my own, the construction of the medical habitus is also an idealisation; it reflects not only how medicine is practice but works with such perspective to articulate how medicine, or in this case medical ethics, should be practiced. My articulation of the medical ethical thinking dispositions builds on the understanding of medical practice offered by Bourdieuan social theory and medical education research that makes use of it. It offers an account of how medical ethics can be practiced given what we know about how professionals in fact practice. If we accept that ought implies can then we can see how the second order normative perspectives of applied (bio)ethics must, and indeed are, be modulated to meet the exigencies of medical practice.

The perspective I have offered recognises that the purpose of medical ethics education is not merely to impart the ability to think or act in certain ways but also seeks to develop the disposition to do so in certain circumstances. This view “goes beyond a skills-centered view and proposes a dispositional approach to the teaching of thinking.... [which] means more than inculcating particular thinking skills; it means teaching students to be disposed to think creatively and critically in appropriate contexts” (Tishman et al. 1993, p. 147). At its best the enculturation of medical ethics should compliment the moral socialisation of medical students and result in professionals who intuitively behave in an ethical manner and, furthermore, as part of this intuitive behaviour engage in creative and critical ethical reflection when and where the circumstances require them to do so.

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