

Receiving Students and Patients: Professional Education and the Double Challenge of Hospitality¹

Claudia W. Ruitenberg

University of British Columbia, Canada

Introduction

Toward the end of *Unlocking the World: Education in an Ethic of Hospitality*, in which I argue for Derrida's ethic of hospitality as a guiding ethic for education, I note that one of the areas of education that I have not yet explored but in which an ethic of hospitality may play out somewhat differently is professional education:

[An] area for further discussion is to what extent and how an ethic of hospitality might guide professional education such as teacher education, medical education, or social work education. After all, this book has emphasized the responsibility of educators for receiving students hospitably, and welcoming them into a particular world of ideas, knowledge, and skills. In professional education, however, and especially in altruistic professions such as medicine and social work, the emphasis is on the final responsibility of the professional toward the patient or client. The professional educator's responsibility toward the student *qua* student does not disappear but must be balanced with the demands of training this student in professional tasks aimed at the best interests of the patient or client.²

Contexts of professional education merit their own analysis and cannot be assumed to respond to the same logic as K-12 or academically oriented postsecondary education. The persistent tendency to think of professional education as professional training suggests that only the educational functions of qualification and (professional) socialization are relevant in professional education, not the function of subjectification in which I, drawing from Gert Biesta's work,³ locate my argument for hospitality. By contrast, I side with those who insist that professional education is not training but indeed education in the fuller sense. For example, about teacher education Marilyn Cochran-Smith writes:

Although the media persists in the language of teacher "training," many teacher educators and educational researchers regard that term as somewhat offensive, implying a narrow kind of behavior shaping or compliance with pre-established rules for demonstrating rote learning rather than a more expansive educational process that focuses on growth and development in the profession.⁴

Similarly, in the field of occupational therapy, Susan Esdaile and Linda Roth argue: "The result of educating, rather than training, practitioners is the creation of professionals who are able to adapt to changes in cultural context and develop new models that they want, and need, in order to meet the needs of the clients they serve."⁵

With that fuller sense of professional education in mind, I aim here to think through how an ethic of hospitality might guide professional education and how the dual responsibility toward the professional student and the "end user" of the profession (patient, client, etc.) may be balanced. More specifically, I take up the case of medical education as one – and a very demanding – form of professional education, and one with which, as I have argued previously, philosophers of education should engage more seriously.⁶

I will argue that hospitality is a fruitful ethic for medical education for three main reasons. The first is that medicine's central institution, the hospital, is a site in which "others" are received, and that already has a history of an ethic of hospitality. In other words, an ethic of hospitality in medical education finds fertile ground both in education and in medicine as practices concerned with the reception of strangers and newcomers. The second reason is that hospitality aligns with some of the principles of bioethics, which are widely accepted and taught in medicine. The third is that, as mentioned above, medical education is not only a form of training or induction into the profession, but also a form of education, understood in the fuller sense of the concept. Medical students and residents should therefore be understood not only as "inductees" into the profession, but also as students, and as such are owed a hospitable reception. After a brief summary of an ethic of hospitality, I will address each of these reasons in turn.

AN ETHIC OF HOSPITALITY

My elaboration of an ethic of hospitality is based on the work of Derrida, who may have referred only rarely to an "ethic of hospitality" under that explicit heading but who has discussed the concept of hospitality in various places. The challenge with an ethic of hospitality is that it departs quite significantly from everyday understandings of "hospitality," especially in relation to power inequality between host and guest: "The core of [an ethic of hospitality] is the idea that those who already inhabit the world do not own it, and that it is a general responsibility to share the world one happens to inhabit and to pass it on to newcomers."⁷ While in a "professional world" it is not the case that professionals just "happen to inhabit" that world – it has more likely taken considerable hard work to come to inhabit it – it does remain true that professionals do not own their profession and operate within it only because, at some earlier point, others have received them in it.

Education guided by an ethic of hospitality self-consciously operates in the gap between past and future, as this year's conference theme reminds us. As I have written elsewhere: "The teacher is aware of having received an inheritance and of having a duty to pass this inheritance on to a new generation. However, this 'passing on' happens not in the form of an uncritical transmission but of a critical translation."⁸ In the section "Hospitality, Induction, and the Medical Student" below I will discuss in greater detail how medical students and residents are situated in the gap between past and future, and how hospitality helps us think through the tensions between socialization into a medical profession with cultures and traditions inherited from the past, and the subjectification of physicians who may change the profession.

In the medical education literature, little has been written about hospitality as a guiding ethic. Alan Bleakley, a medical humanities scholar, discusses hospitality and draws from the work of Levinas in his framing of the concept, but he is primarily interested in how bad team communication in an operating theatre creates ethical problems both for team members who are excluded and treated disrespectfully (e.g., scrub nurses), and for patients who may end up suffering from medical errors resulting from bad communication:

Hospitality is doubly compromised – first by the exclusion tactics of the differing professional groups within the clinical team, conforming to hierarchical conventions; and second, by the knock-on effect of this upon the patient as guest in a team household that is dysfunctional and fails in its basic communications.⁹

In this context, Bleakley does not raise the educational question of how hospitality pertains to the reception and treatment of medical students in the operating theatre and other clinical and nonclinical medical education settings. Elsewhere, Bleakley does address hospitality as an educational value, but his focus there is on the contrast between gendered economies of “commodity exchange” and “gift exchange” that operate in higher education; he does not discuss hospitality or an economy of the gift in the context of medical education.¹⁰

Locating an ethic of hospitality in medical education, understood as a practice that operates at the intersection of medicine and education, thus appears to be a new contribution to the medical education literature. Hopefully, and following my previous provocation to philosophers of education to see “how our ideas hold up against the demands of [medical-educational] practice,” it also makes a contribution to philosophy of education.¹¹ In the next section I address the first reason for proposing hospitality as guiding ethic for medical education: its historical connection to medicine and the hospital.

HOSPITALITY AND THE HOSPITAL

The relation of hospitality to medicine is quite obvious in the word “hospital,” which shares its etymological heritage with hostel, hotel, hospice, and hospitality. According to the Oxford English Dictionary, in the 14th century the word “hospital” was used more generally to designate a place “for the reception and entertainment of pilgrims, travellers, and strangers.” In later centuries the term (in English) came to be used more specifically for those who were, in some way or another, considered “needy,” including poor and elderly persons, young children, and those who were ill or injured.

Sylvia Schafer notes that “hospitalization [was] reserved until relatively recently in western history for the indigent or those without kin or companions.”¹² In other words, family and friends were expected to take care of those who were ill or injured, and only if there were no family or friends to take care of this task would one be offered a place in a hospital as a form of charity, often by churches. Schafer writes: “Beginning in the seventeenth century, French cities began to develop their own institutions of aid alongside the charity of church and parish, including hospitals for both mortally ill indigents and foundlings and poor houses for the institutional placement of those classified as beggars and vagrants.”¹³

The municipal management of hospitals raised new questions, as shown in the debates surrounding 1851 hospital legislation in France. Records from 19th century Marseilles show that members of the municipal council and hospital administrators wondered how the city could “reconcile the open ethical map inspired by the desire to offer medical hospitality to every needy stranger – a moral ambition few were ready to disown completely in this period – with the array of more carefully-policed borders charted both by the 1851 legislation and the demands of sound fiscal policy.”¹⁴ The

sense that a hospital should offer unconditional hospitality, in the sense of a moral duty to *any stranger in need*, regardless of their place of residence, identification, or insurance, is thus deeply inscribed in its history.

Today, the hospital is less a place of respite and recovery – for that we have separate institutions such as the hospice and care home – and more a place of medical diagnosis and treatment. Nonetheless, the sense that the hospital should unconditionally offer a place to those in need has remained, as evidenced, for example, by the 1986 US Emergency Medical Treatment and Labor Act, which requires emergency departments “to treat all patients, even when reimbursement is not guaranteed” because the patient is un- or under-insured.¹⁵ Anne Walker argues that “although a public policy argument has not been used in Canada to support a duty to treat in emergency situations, Canadian courts have expressed sentiments similar to those of the US courts with respect to the role played by hospital emergency departments.”¹⁶ Hospitality has thus remained a value that is relevant to medicine, and medical students and residents need to learn that part of their professional responsibility is to *receive* the patient.

HOSPITALITY AND BIOMEDICAL ETHICS

Although hospitality is still relevant to hospitals and other sites of medical practice, it is not among the ethical values or principles most commonly cited in medicine. Those can be found in Tom Beauchamp and James Childress’s *Principles of Biomedical Ethics*, originally published in 1979 and now in its seventh edition. These principles are: (1) respect for autonomy, which entails both enabling and not interfering with a patient’s autonomous decisions; (2) non-maleficence, which entails refraining from actions that cause harm to others; (3) beneficence, which entails acting for the benefit of others; (4) justice, which entails distributing health care and public health resources fairly.¹⁷

The *Principles of Biomedical Ethics* have been critiqued for several different reasons. For example, Danner Clouser and Bernard Gert argue that principles cannot guide moral practice in medicine, and may actually impede it: “At best, ‘principles’ operate primarily as checklists naming issues worth remembering when considering a biomedical moral issue. At worst ‘principles’ obscure and confuse moral reasoning by their failure to be guidelines and by their eclectic and unsystematic use of moral theory.”¹⁸ Søren Holm agrees that the principles are inadequate for guiding moral practice, not least because they provide insufficient guidance on how they should be balanced and conflicts worked out in specific situations. Even if the principles are used only to lay the groundwork for decisions in practice, however, the problem remains that the American specificity of the principles has been underacknowledged: “Any use of [them] as an analytic tool outside America can therefore only proceed, if the content of the four principles is worked out for the specific cultural context in which the framework is applied.”¹⁹

In spite of these important critiques, the fact that the book is now in its seventh edition attests to its enduring influence. Furthermore, some of the core ideas, such as that medicine is fundamentally about the patient’s health and well-being (however these are conceived), and that the patient, in the context of their family and community

context, should have the final say in treatment decisions, remain quite constant across frameworks. Hospitality is a viable guiding ethic for medical education because it aligns with these accepted principles of biomedical ethics.

The recipient of medical hospitality is, first and foremost, the patient: it is the patient who is received in the space of the hospital, and whose needs should shape the kind of the space the hospital is. The value of hospitality can be seen as related to at least two of the four principles of medical ethics I mentioned earlier – avoiding harm to the patient, and acting in the best interest of the patient – and, I would argue, it is congruent with the value of respecting the patient’s autonomy as well, as a hospitable host does not dictate how the guest should act, but respects the guest’s freedom and choices.

HOSPITALITY, INDUCTION, AND THE MEDICAL STUDENT

Compared to the extensive literature on biomedical ethics in medical education, there is scant literature that takes medical education seriously as an *educational* enterprise for which not only medical but also educational ethics is relevant. An exception to this is William Branch Jr’s work on the ethics of caring as an ethical framework for medical education.²⁰ Branch argues not only that caring is a suitable framework for medical practice, and that medical students should be taught and encouraged to care, but also that caring ought to be enacted in medical education. In other words, he proposes that both patients and students should be recipients of care: “I doubt we will ever approach an ideal caring atmosphere for patients unless we extend our caring to our students, residents, peers, and ourselves. Harsh treatment of other caregivers is unlikely to coexist with warmth and support for patients.”²¹

I appreciate Branch’s attentiveness to medical education as itself a practice deserving of an ethical framework, and not only a vehicle to the practice of medicine. With respect to an ethical framework of hospitality, it may be the case that, parallel to Branch’s argument, it is unlikely we are able to extend hospitality to patients unless we extend hospitality to students, residents, and peers. However, my emphasis in this article is slightly different, and takes its inspiration from Christopher Martin’s question: “If we are going to take responsibility for the education of persons who are to become doctors, what do we owe these persons?”²² In other words, regardless of the practical possibility that medical students and residents who are received hospitably into the profession may themselves be more likely to receive their patients hospitably, I want to focus on medical education as a practice that has a dual responsibility not only to the patients treated by students and residents, but also to the students and residents themselves.

Biesta acknowledges that professional education is legitimately concerned with qualification, that is, “providing [students] with the knowledge, skills and understanding and often also with the dispositions and forms of judgement” necessary for a particular task, set of tasks, or more complex job, as well as with socialization, that is, “the transmission of particular norms and values” that enable membership of a particular professional “order.”²³ Indeed, the medical education literature confirms a strong emphasis both on the assessment of the knowledge and skills that qualify new doctors, and on socialization: “Medical education is often described as a form of

professional socialization and moral enculturation whereby the profession transmits normative expectations for behaviour and emotions to its novices.”²⁴

I align myself here with those who have argued that “any education worthy of its name should always contribute to processes of subjectification,” a view that Biesta cites but which he neither supports nor opposes.²⁵ Medical students and residents need to be able to become, to borrow Biesta’s language, “specimens” of the more encompassing order of the medical profession, but they also need to be *critical* specimens who change the professional order of which they are a part.

Earlier I referred to the idea of education as a “critical translation” of received knowledge and skills. This idea is particularly apt in medical education as research continues to correct and refine medical knowledge and skills, and medical students and residents themselves, steeped in the latest research, may be the ones to remind their educators that insights into the best treatment options and protocols have changed. Moreover, the medical profession changes not just under the influence of the productive tension between medical socialization and new insights from medical research, but also under the influence of patients whose access to medical knowledge has increased and who have become more informed and vocal participants in their healthcare.

An ethic of hospitality draws attention to the fact that changes in medical practice have occurred only because some practitioners have questioned the knowledge and skills they were introduced to. For example, because in 1981 then 30-year old clinical fellow Barry Marshall took up Robin Warren’s research on bacteria in the stomach lining, and was willing to question the accepted knowledge and treatment of gastritis and ulcers, we now understand the role of *Helicobacter Pylori* and its treatment with antibiotics.²⁶ The high stakes of a profession such as medicine may impose greater constraints on the places where students can be received hospitably, but, nonetheless, they will be the next generation of experts who will take the profession in new directions, and who will make changes to how things are done. This ability of professionals to change the professional tradition into which they are received is precisely what Esdaile and Roth emphasize when they insist that the education of occupational therapists is education and not training: it needs to foster in occupational therapists an ability “to adapt to changes in cultural context and develop new models that they want, and need.”²⁷

Arendt speaks of the “ruin” that would befall the world if we were to stand in the way of its renewal. I do not want to equate the Arendtian conception of newness that comes into the world through natality, with the innovations brought to a profession through professional newcomers. Nonetheless, the need to protect the profession from newcomers, while enabling the renewal and survival of the profession by welcoming newcomers, strikes me as a profoundly Arendtian challenge of hospitality.²⁸

The idea of educational hospitality as leaving space for newcomers, letting newcomers arrive and make a home for themselves, may seem counterintuitive in medical education, as there are good reasons for insisting that students must be trained rigorously in a range of medical procedures, and that is not up to them to “make

themselves at home” in these procedures. In the interest of patient safety, students need to be initiated into certain techniques and practices. However, in addition to changing scientific knowledge and treatment options, students learn many things that are not about factual knowledge or technical skills, such as communication with patients and their families, and collaboration with colleagues from other health professions. Medical education is more than clinical training, and the challenge is not just to prepare technicians who can skillfully carry out medical procedures, but to educate persons who have an understanding of the meaning of illness experience in a patient’s and family’s life, who can weigh conflicting principles of medical ethics in concrete situations, and who have an appreciation of the moral burden that comes with the social status and privilege of the profession. If medical education aims to create, as Martin puts it, “an educated person who is also a doctor,”²⁹ then the question for medical educators is both how to train this person to apply established principles of medical ethics, and how to educate this person to work thoughtfully and critically with the values, including hospitality, that guide what medical care is about. Moreover, medical educators owe it to their medical students and residents, as well as to the profession in which they themselves have been received, to receive newcomers hospitably, so that the profession can be continued and renewed.

CONCLUSION

James Tessaro recently sketched the scene of hospitality as follows: if medical educators are in the position of hosts, the patients are undeniably the VIPs at the party, while students and residents assist in hosting, progressing from simpler tasks (carrying plates of canapés) to more complex ones (serving champagne flutes).³⁰ But the challenge is that medical students and residents cannot be only “apprentice hosts,” carrying out tasks designed by others. If they are to become fully-fledged hosts, capable of truly welcoming patients, they must come to feel at home in their profession. For that reason, medical educators have to attend not only to the needs of patients, but also to those of medical students and residents, helping them to find a professional home for themselves. The safety and wellbeing of patients are paramount, but the renewal of the medical profession demands that newcomers are received hospitably.

In response to my question “to what extent and how an ethic of hospitality might guide professional education,” I conclude that hospitality is especially productive for thinking through some of the challenges in medical education. In particular, it allows us to ask pointed questions about who does and doesn’t “fit” in what Ian Scott has called “the house of medicine.”³¹ When an applicant, student, resident, or graduate is perceived not to “fit” in the medical profession, the framework of hospitality raises questions about the justification of the conditions imposed on the newcomer. Perhaps there are good reasons not to admit someone to, or more deeply into, the “house of medicine” if that person has not met certain well-justified criteria of clinical knowledge or skills; in other instances, the house of medicine may be unnecessarily inhospitable, and the criteria for entrance based more on the habits and comfort of the ones who already dwell in it. The metaphors associated with hospitality are generative, suggesting questions not only about the capaciousness of

the “house” or “houses” of medicine but also about the array of hosts. Those who host newcomers in the medical profession, after all, include not only those tasked explicitly with medical education, but also members of other health professions (nursing, pharmacy, etc.), and even the patients who reside in it and who expect physicians to be and act in certain ways.

As I have observed elsewhere, the philosophical literature on hospitality often relies on the schematic presentation of “the host” and “the guest” as if each of these were singular. In lived educational situations, by contrast, educators rarely find themselves in the presence of only one student, so attention has to be divided between multiple students: “Educational situations, especially those in institutional forms of education, are nearly always situations of more than two.”³² In medical education, even if the educator is in the presence of only one student, that educator cannot afford only to attend to the student in front of them, as the interest of the patient must always be attended to. This is the case not only when a patient is physically present in the educational scene, such as in bedside teaching, or when a patient is being discussed by the educator and the medical student or resident; no, the student or resident must also share the educator’s attention with a hypothetical patient, a patient whom the student or resident may go on to diagnose or treat at some point in the future. This means that in medical and other forms of professional education, the educator’s attention is necessarily more divided than in non-professional education. But while hospitality is perhaps even more challenging in medical education than in other forms of education, it is a worthwhile framework and ethos. Medical students are not only almost-professionals who owe care to patients, but are also students who are owed education and training. Medical educators, therefore, are responsible both for the safety and wellbeing of patients and for helping students across the threshold of medical practice.

1. Earlier versions of this paper were presented at the ProPEL conference, June 2014, and the Centre for Health Education Scholarship (CHES), October 2015.

2. Claudia W. Ruitenberg, *Unlocking the World: Education in an Ethic of Hospitality* (Boulder, CO: Paradigm, 2015), 140.

3. Gert Biesta, “Good Education in an Age of Measurement: On the Need to Reconnect with the Question of Purpose in Education,” *Educational Assessment, Evaluation and Accountability* 21, no. 1 (2009): 33-46.

4. Marilyn Cochran-Smith, “The Future of Teacher Education: Framing the Questions that Matter,” *Teaching Education* 11, no. 1 (2000): 13-24, 16.

5. Susan A. Esdaile and Linda M. Roth, “Education not Training: The Challenge of Developing Professional Autonomy,” *Occupational Therapy International* 7, no. 3 (2000): 147-152, 150.

6. Claudia W. Ruitenberg, “Physicians in Philosophy of Education: From Cameo Appearance to Leading Role,” in *Philosophy of Education 2013*, ed. C. Mayo (Urbana-Champaign, IL: Philosophy of Education Society, 2014).

7. Ruitenberg, *Unlocking the World*, 16.

8. Ruitenberg, *Unlocking the World*, 74.

9. Alan Bleakley, “A Common Body of Care: The Ethics and Politics of Teamwork in the Operating Theater are Inseparable,” *The Journal of Medicine and Philosophy* 31, no. 3 (2006): 305-322, 319.

10. Alan Bleakley, "Teaching as Hospitality: The Gendered 'Gift' and Teaching Style," in *Gender, Teaching, and Research in Higher Education: Challenges for the 21st Century*, ed. Gillian Howie and Ashley Tauchert (Aldershot, UK: Ashgate, 2002).
11. Ruitenberg, "Physicians in Philosophy of Education," 153.
12. Sylvia Schafer, "Admitting the Stranger: The Rule of Law, the Ethics of Medical Hospitality," *Law Text Culture* 5 (2000): 341-376, 342.
13. Schafer, "Admitting the Stranger," 346.
14. Schafer, "Admitting the Stranger," 359.
15. Stephen Trzeciak and Emanuel P. Rivers, "Emergency Department Overcrowding in the United States: An Emerging Threat to Patient Safety and Public Health," *Emergency Medicine Journal* 20, no. 5 (2003): 402-405, 402.
16. Anne F. Walker, "The Legal Duty of Physicians and Hospitals to Provide Emergency Care," *Canadian Medical Association Journal* 166, no. 4 (2002): 465-469, 467.
17. Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics, 7th edition* (New York: Oxford University Press, 2013).
18. K. Danner Clouser and Bernard Gert, "A Critique of Principlism," *The Journal of Medicine and Philosophy* 15, no. 2 (1990): 219-236, 220.
19. Søren Holm, "Not Just Autonomy – The Principles of American Biomedical Ethics," *Journal of Medical Ethics* 21, no. 6 (1995): 332-338, 337.
20. Though Branch draws from the work of Gilligan and Noddings, he uses the phrase "ethics of caring" rather than "ethics of care."
21. William T. Branch Jr., "The Ethics of Caring and Medical Education," *Academic Medicine* 75, no. 2 (2000): 127-132, 130.
22. Christopher Martin, "Reconstructing a Lost Tradition: The Philosophy of Medical Education in an Age of Reform," *Medical Education* 47, no. 1 (2013): 33-39, 34.
23. Biesta, "Good Education in an Age of Measurement," 39-40.
24. Crystal Jaye, Tony Egan, and Kelby Smith-Han, "Communities of Clinical Practice and Normalising Technologies of Self: Learning to Fit in on the Surgical Ward," *Anthropology & Medicine* 17, no. 1 (2010): 59-74, 60.
25. Biesta, "Good Education in an Age of Measurement," 41.
26. *Barry J. Marshall Biographical*. Accessed from the Nobel Foundation, http://www.nobelprize.org/nobel_prizes/medicine/laureates/2005/marshall-bio.html
27. Esdaile and Roth, "Education not Training," 150.
28. Hannah Arendt, "The Crisis in Education," *Between Past and Future* (New York: Penguin, 1977), 196.
29. Martin, "Reconstructing a Lost Tradition," 34.
30. James Tessaro is a General Internist and Clinical Educator Fellow at CHES.
31. Ian Scott is a Family Physician and Director of CHES.
32. Ruitenberg, *Unlocking the World*, 112.