The Treachery of Images: How René Magritte Informs Medical Education

Delese Wear, PhD¹ and Joseph Zarconi, MD^{2,3}

¹Behavioral and Community Health Sciences, Northeastern Ohio Universities College of Medicine, Rootstown, OH, USA; ²Medical Education, Summa Health System, Akron, OH, USA; ³Internal Medicine, Northeastern Ohio Universities College of Medicine, Rootstown, OH, USA.

Using René Magritte's well-known painting *The Treachery of Images* (*This is not a pipe*), we argue that the current focus on competencies throughout medical education can sometimes lead educators to rely too heavily on scores, checkmarks, or other forms of assessment that come to be viewed as equivalents for the actual existence of what is being measured. Magritte insisted that the image he created on the canvas was not a pipe but rather a representation of a pipe, an important distinction for educators to remember as we seek ways to evaluate trainees' attainment of the fundamental knowledge and skills of the profession. We also urge that the focus on broader skills, values, flexibility, reflection, and insight development should fall outside the net of a competency orientation in a supportive environment spared from traditional assessment methods, using a classroom in undergraduate medical education as an example of working toward this end.

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Twelve second-year medical students and two faculty preceptors sit around a conference table discussing a short story assigned for their required *Reflections on Doctoring* seminar that spans the first 3 years of medical school. To date we have read Raymond Carver's story "A Small, Good Thing"¹, an exploration of loss and the profound need for human connection in the face of grief; Rafael Campo's essay "Like a Prayer"², a reflection on respect for patients and our shared humanity; Adam Haslett's story "The Good Doctor"³, an examination of what it means to listen and what it feels like to be understood; and Perri Klass's "Crying in the Hospital"⁴, a rumination on the expression of emotions in clinical settings still resounding 20 years after its publication. In addition to reading these works, students write personal reflections on the meanings they derive from each assignment. The hour and a half of class time, then, is devoted to just that: meanings.

Like students found at any medical school, ours have varied personalities, some robustly forthright, others quietly pensive. Some are superb writers; others have modest skills at best. A fair number of them understand what it means to reflect on issues in very personal ways, while others struggle to do more than retell the assigned story. Many look forward to these seminars, others are ambivalent, and some find them useless. Yet even if the consistently high evaluations the *Reflections on Doctoring* experience receives were hidden from us, we would still sense something essential going on in and around these classes: the occasional epiphany experienced by a student while reading the assigned story; the gift of insight that occurs as a student sits at her computer reflecting on what she's read; the moments of scrutinizing one's values and beliefs while sitting around a table in a conference room, impenetrable to the competency gaze. These sites are safe harbors for all students, regardless of whether they were seeking such spaces or not.

What goes on during these hours is not unique to our medical school. Such experiences are increasingly found in formal and informal settings throughout medical education, and offer great potential for the kinds of physicians students become. It is here where students unload their conundrums, bafflements, and insecurities around a table where habits of reflection, trust, vulnerability, respect, empathy, and honesty are valued and modeled. There is no examination, no competition, and no pimping. In this setting, we are not interested in ranking or assessing the student's level of professionalism or her knowledge of systems-based practice. These competencies, while critically important in learner assessment, far too often become the sole focus of the medical education enterprise. Hundert and Epstein's widely used definition states that competency is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, *emotions, values, and reflection*"⁵ (emphasis authors'). We argue that the competency assessment pendulum, which describes different attributes of a physician, has swung too far. In no way do we dismiss the idea that a baseline for knowledge and skills is critical in the education of physicians, and that the concept of competencies is one way to ensure that trainees have met those marks. Careful evaluation and feedback exist throughout medical education at all levels, and our intent is not to disparage such efforts—including those that delineate standards all students must meet. Rather, we raise fundamental concerns about our penchant to slice everything students do into a performance, be it knowledge-based, behavioral or attitudinal. We argue that focusing on competency development *alone*—without a concurrent emphasis on broader skills, values, flexibility, reflection, and insight development—is a distorted pedagogy.

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As part of a series in 1928–1929, Belgian surrealist artist Rene Magritte created what is one of his most famous paintings, *The Treachery of Images* (*"Ceci n'est pas une pipe"*). The painting is a realistic rendition of a pipe that fills up most of the canvas with the title, "This is not a pipe," painted in script below it. Although this familiar image has filled volumes of texts about art, signs, and representation, Magritte's message is relatively simple: The image on the canvas is not a pipe, but a portrayal or a representation of a pipe. As Magritte himself observed, *"The famous pipe. How people reproached me for it! And yet, could you stuff my pipe? No, it's just a representation, is it not? So if I had written on my picture 'This is a pipe,' I'd have been lying!"*⁶

This essay focuses on questions of representation, on how we have moved throughout medical education to the belief that a score, a checkmark, even a written narrative assessment of an entity deemed to be a competency denotes an equivalency for the actual existence of what is being measured.

Magritte's point was all about representation, which has everything to do with contemporary medical education's current intense focus on competencies. As Brooks describes it, "To read a journal article or an official document in medical education is to be washed over by waves of general competencies, core competencies, cultural competency, communication-skills competency, competency assessment, and competency-based-you-name-it"⁷. In fact, the vast majority of educational activities in the medical curriculum are tied to one or more competencies. That is, if a trainee exhibits an agreed-upon level of knowledge, skills, values, or other attributes, ostensibly that person is deemed "baseline competent" in those areas. But does the time spent around the conference table described above involve a competency or set of competencies for students? Certainly one might argue that substantive, meaningful interaction between and among students and faculty arises from the reflective activity preceding this event and continuing during the discussion. But to use a template of behaviors and assumed attitudes to make sense of what happens around that table is to vastly diminish its profundity and possible meanings. Students may be "enacting" some unique-to-them form of reflection, but none of their behaviors and attitudes can be selected singly or collectively to *represent* reflection...and this does not even begin to address issues of sincerity and authenticity. *C'est ne pas une pipe*.

Like the conventional equivalency between a "real" pipe and the image of a pipe, competencies assume a conventional equivalency between certain actions and attitudes and a particular concept like "reflectiveness." And because of our devotion to assessment in medicine, we cast an increasingly wide net and now find ourselves including such characteristics as reflectiveness as a competency. Yet reflectiveness, both solitary and in group settings, is something else, more nuanced yet vital, and should be spared from traditional assessment methods precisely because it is so deeply personal, variously experienced, and distinctly manifested. Reflectiveness cannot be legislated; it is not a predetermined set of actions or attributes, both seen and unseen; its "content" does not involve pietistic "truths" or predefined answers that we're looking for students to display with a passive receptivity. Yet calls to develop rubrics for reflection, particularly reflective writing, abound in medical education, and are increasingly found in premier medical education journals^{8,9}.

Despite all our yearnings for certainty, the kind of reflectiveness we hope students engage in now and as a life-long

process cannot be found in the language of empirical science or by quantitative means. Open-ended questions with answers that are always partial and contingent circulate throughout the time students spend alone reading, thinking, and writing; they also circulate around the conference room table when students and faculty are assembled for discussion. Regardless of the topic at hand, the questions posed are all linked back to students' (and faculty's) search for meaning: What do I believe? What do I value? What is my purpose? How do I craft relationships with others? What gets in the way of caring for others? What is the moral basis of medicine? When I'm at my best, how do I look? What frightens me about a life in medicine? What excites me? How will I be in medicine?

We propose that there be elements of medical education that are off limits to the competency gaze, where reflectiveness and the imagination can exist in an environment without a tie to competencies. Across-the-board use of competencies may lead to a truncated self image whereby one is always on stage, one is always "performing"—the development of a veneer without any depth. This persistent competency mindset demeans the relationships we attempt to develop with our students that are evolving rather than fixed, collegial rather than hierarchical, transparent rather than professionally guarded. Or, as Alan Bleakley eloquently puts it, the competency movement risks acceptance of the "good enough" rather than the cultivation of *capabilities* that are adaptive, sensitive, and dialogical, capabilities that are not easily "testable or measurable...except for a narrow band of behaviors"¹⁰. Moreover, even Wald and Reis, who have suggested ways to "objectively" assess student reflective writing, noted recently in the pages of this journal their concerns with trainees' authenticity as these more formal assessments of reflection/reflective writing are used⁹; one of us has raised a similar question that asks if we care as much about authenticity and sincerity as we do about behavioral manifestations of particular qualities in evaluative circumstances¹¹.

We may teach students how to perform competently for the purpose of yet another competency-based assessment, and miss the opportunity to provoke meaningful self exploration about what and who they are becoming as emerging physicians, and what such becoming means to them. Philosopher and educator Maxine Greene offers a counter to such performance, suggesting that "to be thoughtful about what we are doing is to be conscious of ourselves struggling to make meanings, to make critical sense of what authoritative others are offering as objectively 'real'"¹². This, it seems, is what students may feel empowered to do when invited to talk about values and emotions, particularly their own, but only when they are provided with an affirming environment with faculty who are also willingly take such risks.

In fact, one of the most absorbing discussions we had in *Reflections on Doctoring* was when we read accounts of physicians taking their white coats off, both literally and figuratively. John Stone's poem "Talking to the Family" evokes a vulnerable uncertainty in students as they ponder at the intersection of their personal lives and professional identities, wondering how they will "take off the coat,/drive home,/and replace the light bulb in the hall"¹³. We read Audrey Shafer's "Monday Morning"¹⁴, a rumination on the back and forth between her sleepy 3-year-old she has just left "in the prelight" at home and the soon-to-be-sleeping patient in the surgery suite. And we read Joseph Zarconi's "Legal Advice"¹⁵, a

physician's "difficult patient" story that teaches him the power of his own suffering.

We strongly believe that if students experience this kind of supportive, non-evaluative environment for reflection throughout their medical education that they may be more likely to bring such practices to their lives as physicians. That is, they may be more conscious, or as Maxine Greene puts it, more "wide awake"¹⁶ to the human uncertainties, intricacies, beauty, and suffering that lie outside of evidence and evaluations. Can this be taught directly? Of course not, but we have faith that offering an environment where such puzzling is routinized and ongoing, where uncertainty prevails far more than answers, and where expressions of fear and vulnerability are met with kindness and authentic collegiality—all these may influence trainees' professional identities, including their relationships with patients.

Indeed, if students consistently experience moments when they are off the evaluative grid, when they experience, firsthand, the limitations of categories, organizers, test items, scores and stages, perhaps they, too, might look beyond the language and protocols of the medical record in their relationships with patients. The medical record is critically essential to the care of the patient; it contains "truths" about the patient. But like competencies, it offers only part of the story; it offers only partial "truths." In addition, when students are provided opportunities to reflect upon the lived experiences of their patients without concerning themselves with "getting it right," or with being judged as incompetent, they may be able to develop deeper empathy for their patients as well as for themselves. They may come to see through multiple lenses, from numerous perspectives, and may carry this broader seeing into their caring for others.

Like the recent call in the *Chronicle of Higher Education*¹⁷ to do more teaching "naked" (without technology of any kind, just teachers and students interacting with one another), we should devote more time in medical education to crafting "naked" experiences for our students, unattached to competencies. Classroom work that nurtures reflectiveness, authenticity, listening, empathy, and vulnerability captures learners in all their particularities, all with different biographies, ways of making sense, and habits of acting on the world. Such work is not directed at how to *do* something competently. Rather, this work allows students to focus inwardly on how to *be*. We cheat our students if we sift their reflective work and honest musings into nuggets of competencies we can measure, rank order, and

include in dean's letters and bar graph demonstrations of their performance. A snapshot of these classroom experiences, taken for the purposes of objective, competency-based assessment, misses the point quite broadly. Such a snapshot, most certainly, is not a pipe.

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Corresponding Author: Delese Wear, PhD; Behavioral and Community Health Sciences, Northeastern Ohio Universities College of Medicine, 4209 State Route 44, Rootstown, OH 44272, USA (e-mail: dw@neoucom.edu).

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