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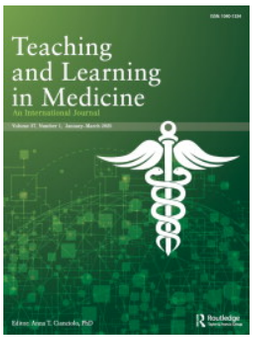

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PHILOSOPHY IN MEDICAL EDUCATION

Exploring Untested Feasibilities: Critical Pedagogy's Approach to Addressing Abuse and Oppression in Medical Education

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ABSTRACT

Abuse and oppression in medical education persists. Particularly when transitioning to practice, students and residents face dissonance between what they perceive as the ideals of patient care and reality. They witness, and eventually take part in, joking about fellow students and patients, discriminating against minorities, and imposing unbearable workload to subordinates, to mention some practices that have been normalized as the reality of medical training, beyond any possibility of change. We suggest that Critical Pedagogy, an educational movement rooted in Brazil that aims to empower learners and educators as full citizens, can help medical education reinstitute hope for a more humanistic culture by testing new realistic transformative actions, i.e., untested feasibilities, to promote change. We use vignettes based on real situations of oppression to present three concepts of Critical Pedagogy contextualized to medical education: (a) critical consciousness as *praxis*; (b) pedagogy with learners; and (c) education as a democratic relationship between individuals. The vignettes explore how each one of these concepts can support educators and learners to break chains of injustice and oppression. Perceiving disagreements as opportunities for change, legitimizing the perspectives and values of all engaged in analyzing reality, is needed to nurture critical consciousness. Critical Pedagogy understands education as a partnership of trust between learners and educators and seeks a pedagogy that is built with learners, not on them. Finally, we present suggestions for individual- and systems-level actions that can translate these principles of Critical Pedagogy into a *praxis* of untested feasibilities for medical education.

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Introduction

While acknowledging the need to nurture an attitude of compassion and social accountability throughout medical training,[1–3] medical education still harbors a culture of abuse toward learners and patients.[4–15] This resistance to change is often enacted by the hidden curriculum in medicine, which perpetuates a culture of oppression.[6,16] To address this contradiction, several policies regulating behavior in institutional and clinical settings were developed and implemented, indicating to learners and society that integrity, respect for diversity, patient centered care, and social justice represent the core of the medical professional identity.[3,17–21] As part of this paradigm, an effort to nurture metacognitive skills, especially through reflective practice, has emerged as a significant trend in medical training, laying a strong foundation for enhancing critical thinking among learners and educators.[22–24] Building on this foundation, we propose that Paulo Freire's Critical Pedagogy,[25,26] with its emphasis on conscientization and *praxis* to overcome oppression, may help us move forward. In this perspective, we present, contextualize and discuss key concepts of Freire's Critical Pedagogy, while exploring how these concepts could be operationalized into educational attitudes and practices.

What is critical pedagogy?

Critical Pedagogy is an educational movement rooted in Brazil during the 1950s and 1960s—decades marked by industrialization, rural-to-urban migration, and political turmoil that culminated in a military dictatorship.[27] Access to public services, including education,

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was limited. Especially in rural areas, primary education enrollment was low, while secondary education was even less accessible.[27,28] Overall, 40% of Brazilian adults were illiterate and education policies by then favored technical education.[28,29] These decades were also marked by an emerging social claim for increased access to education.[30] Brazilian elites used lack of access to education and the resultant higher levels of illiteracy as an instrument of domination to keep the *status quo* of an extremely inequal society. A movement of Brazilian philosophers and educators, including Paulo Freire, in the meantime, was actively and intentionally conceptualizing education as a means to enact social change toward social justice.[30–32]

In this context, Paulo Freire ran a successful and innovative educational intervention to promote literacy among adults in an impoverished rural community. Freire's intervention, built on the culture and context of students, integrated learning to read with learning to become protagonists of their own history, as opposed to being resigned spectators of the unjust reality in which they lived. Most students enrolled in the program learned to read in a short period of time, and Freire's intervention gained national attention. This experience was followed by further reflections on education, which made Freire a protagonist in a movement that gained visibility later in the 1980s in Anglo-American academia: Critical Pedagogy (CP). Freire's prolific work, especially his *Pedagogy of the Oppressed,* is one of the mainstays of CP and made him one of the most cited education scholars worldwide.[32] We believe this international recognition shows how educators cultivate hope that education should not be the reproduction of social norms and values, but a venue to reflect and act on these norms and values to achieve social justice and promote freedom.

CP conceptualizes education as a culturally situated and mediated endeavor that aims to empower people as full citizens, aware of their social realities, and committed to democracy and social justice. For CP, education is a socio-political process with a profound impact on society. This perspective opposes what Freire called "banking education,"[26] an implicit understanding that the purpose of education is to share knowledge and to prepare individuals to perform specific (and repetitive) professional tasks while remaining neutral about the context in which it happens. CP, on the other hand, understands that there are no neutral educational practices or processes. Aligned with post-positivist critics who saw the alleged neutrality in science as a limitation on comprehending complex social processes, Freire understood the choice toward banking education as a (hidden) political decision for continuity of the *status quo*. In the communities that inspired Freire's work, the *status quo* was one of social inequality and de-humanization. A "neutral" education in such context, by disregarding students' reality, becomes an instrument of oppression.[26] In a "neutral" education, the purpose of teaching an adult marginalized by poverty to read would be shaping this adult to better fit such reality, not to challenge it. Likewise, a "neutral" medical education would train students and residents to navigate oppression without challenging it. The "neutrality" in education carries, therefore, an (un)ethical choice. For instance, if a clinical teacher witnesses the oppression of learners and does not act on that oppression, this clinical teacher becomes part of this oppressive system.

How does critical pedagogy relate to medical education?

Oppression is not restricted to socially vulnerable individuals and communities. The dynamics of power are complex, and one can be oppressed and oppressor depending on the moment and context. Despite coming mostly from wealthy privileged environments, when joining medical school students assume vulnerable positions relative to teachers, supervisors, and seniors.[5,11] Sustained exclusion, pimping education, insults, excessive workload, racial discrimination, and unwanted sexual attention are examples of a culture of oppression that have been extensively reported among medical trainees and across different specialties.[5–13,33–35] The abuses are frequently minimized and perceived as strategies to cope with stress and rites of passage.[5,6,8] They are embedded and normalized as *the* unchangeable culture of the medical profession, something that one needs to cope with (and overcome), not to challenge. Adding to this, students and residents who confront injustices are frequently labeled as complainers, a dismissive attitude that undermines their legitimate reaction to oppression.[36] This resembles what the poor communities that inspired Freire's work experienced in their poverty and social exclusion.

In a context of oppression, many people perceive their reality as sad and unjust but see no way out of it. Those who believe in change and try to act against it are repressed. Oppression creates a perception that reality is fixed, unchangeable by people's actions. This hopelessness for change is a very important target for educators willing to incorporate CP in their practices. According to Freire, in hopelessness prevails the naïve thinking that conformity is the sole viable option. To conform with oppression, one must accept the role of oppressed or to become the oppressor.[25,26] This

helps understand the complexities of relations of power and why some younger generations of medical students and doctors keep reproducing the oppression they have experienced.

To counteract this naïve perspective, Freire proposes to reinstate hope for change through critical consciousness: understanding and acting on the contexts that shape different realities. Freire understood hope as the catalyzer of human agency and creativity.[25,26,37]

Reinstating hope

Hope for change starts with situating the individuals in a contextual reality, with its social, political and economic dimensions - a critical standpoint of CP. It requires a movement of "stepping outside" reality to allow awareness of the paradigms supporting power relations in this reality. Understanding and situating the causes of oppression, injustices and inequalities into one reality makes it possible to aspire to alternative and better realities. Believing in a better reality means accepting the unfinishedness of it. Acknowledging there is no such thing as a finished culture, environment or society, allows the reinstatement of hope for change. Hope in Freire's perspective, however, is not a passive optimism that reality will improve spontaneously, but a critical engagement with reality. Hope in CP is agency, not primarily through radical actions or profound interventions, but mostly by experimenting with new, feasible possibilities- a concept Freire referred to as *untested feasibility.*[26,37]

Untested feasibility is the possibility of doing something that has not being tested before to improve reality within one's political, emotional, cognitive and ethical reach.[26,37] It is a combination of reflection and action supported by the hope for change that minimizes the personal risks of provoking change. It is important to highlight the conceptualization of untested feasibility as *praxis*, which requires transformative cycles of reflection and action. This process involves critically examining experiences and refining ideas through dialogue with differing viewpoints and then applying what was learned to improve practices. From the perspective of CP, reflection that is not followed by action does not qualify as *praxis*; it is merely "verbalism." [25,26]

To explore untested feasibilities, CP proposes problematization.[26] Building educational practices around concrete tasks or problems relevant to learners allows the parallel development of academic skills and critical consciousness. Critical consciousness is a capacity to identify and act upon the oppressive forces limiting an individual to be or become.[26] We recognize the effort of modern medical education to adopt educational practices that focus on relevant problems, clearly connected to medical practice, while striving to engage learners in the learning processes and promoting self-regulation. However, problematization for Freire is not only about learning to solve professional problems autonomously, but also about cultivating agency to change learners' reality. For instance, educational activities based on such problematization would invite learners to bring the oppressive elements of medical culture, as perceived by them, to the center of the educational practice. The aim would be to rehearse ways to change this culture considering its political, social, and economic dimensions and constraints. Such multi-faceted problems should prepare learners to engage with and transform their realities.[25,26,37] In this way, the educational and healthcare systems are part of the "problem" to be solved (and the culture to be changed). To take the next step toward "problematizing" medical education demands curricular spaces in which learners come up with their own agenda combined with a call for reflection and action upon the oppressive elements of the medical culture.

This effort to "problematize" medical education needs to go beyond initiatives to contextualize learning and assessment of medical knowledge within clinical care. As a community, we medical educators need to acknowledge the limited impact of such initiatives in promoting cultural change.[33] Actually, these initiatives were an effective first step; our community has understood the importance of leaving behind paternalism and adopting student-centered practices. However, there is no such thing as a finished medical education. To enact cultural change, we need to keep moving.

One possible interpretation of this barrier to cultural change within the framework of CP is that what was once an untested feasibility, after cycles of contextualization and reflection, becomes the new reality – a renewed reality but not necessarily free from oppression. This new reality, while an improvement on the previous one, asks for new, fresh untested feasibilities. Failing to acknowledge this continuous need for change would be to disregard those who continue to experience abuse and injustices throughout medical training.

We, the authors of this essay, believe that nurturing continuous cycles of untested feasibilities can be achieved by integrating relevant concepts of CP into medical education such as (a) critical consciousness as *praxis*; (b) pedagogy with learners; and (c) education as a democratic relationship between individuals.

In the following sections, to illustrate these CP concepts and how they can move us toward a medical education culture that resists oppression, we present three vignettes based on situations we have experienced as learners and/or educators. Our intention is to contextualize Freire's CP within medical education while inspiring medical educators to experiment with such practices. Each vignette is followed by an explanation of how we see power relations leading to oppression, how it could be used in problematization, and the (un)tested feasibilities we see in it.

Before presenting the vignettes, however, we would like to acknowledge our standpoints as authors. We are Brazilian internal medicine doctors with extensive experience supervising medical students and residents while caring for socially vulnerable patients. Both of us have transitioned to careers as researchers in medical education, and our primary role as educators is now to support the training of future generations of researchers. Acknowledging that, like anyone, we have oppressors within ourselves, we strive to counteract them through self-criticism and deliberately seeking to incorporate CP in our daily practices as educators and citizens.

Critical consciousness as praxis

The patient waited for over two hours in the outpatient clinic before being called to the consultation. He was angry. The student, in his first weeks of patient care, begins the interview by apologizing for the delay. The attending physician interferes saying she will not apologize for doing her best to keep caring for more patients and students than she can manage. She believes that the healthcare system should be held responsible for the delay, not them. The student, embarrassed and confused, manages to complete the consultation, after which neither he nor the attending physician talk about what happened. Later that day, he thinks about the differences between what he had learned previously in classes and simulated practice and the real world, and how he should adjust to it.

Oppression as we see it

Clear acts of oppression on patients frequently enact a subtler oppression upon learners. The reality of clinical practice, for example, sometimes contrasts with learners' own initial ideals of patient care and what they were taught in the pre-clinical years. The student in our vignette probably heard in his previous years of medical training how the patient is the vulnerable one in the relationship with health professionals and health care systems. He probably reflected upon hypothetical situations like the one described and how to deal with it: to empathize with the patient, see the situation through his perspective, and do his best to provide a positive outcome. However, in the real clinical scenario, the student was oppressed in his empathetic *praxis*, leaving him in a state of uncertainty. As medical professional behavior is largely learned through role-modeling,[38,39] it will not be surprising if, in the future, he reacts to a similar situation emulating the attending physician.

Problematization

Dissonances between idealizations, personal values, discourse, and *praxis* are common in medical training.[11,34,35,40–42] Supporting faculty development is crucial for achieving better alignment, but it is unrealistic to assume that all contradictions between expectations and reality from medical training can be eliminated. Developing a critical consciousness about health care and educational systems can support learners navigating dissonances.[39] This vignette exemplifies how the student and the attending physician are compelled to make choices between being faithful to their own values and needs, the patient's needs, and the demands of the educational and healthcare systems.[40–42] The heavy workload the attending physician does not feel able to cope with can also be considered an act of oppression. Possibly unaware of her dual role, and oppressed by excessive workload, she oppresses the student in his empathetic attitude and the patient in his legitimate anger.

The untested feasibility

Learners who develop critical consciousness can break such chains of oppression. Alignment of values and behaviors in anti-oppressive *praxis* can be achieved by continuous cycles of actions followed by critical reflection. A reflection that is curious, open to the other, permeated by self-criticism, and aiming for change. This approach has practical appeal and searches for alternative behaviors, hoping for improvement. It happens in a nonhierarchical, dialogical space where ideas for action are freely exchanged and even rehearsed.[25,26] We advocate that clinical rotations should be permeated by reflective spaces, in which learners can slow down and make the time to address the clash between idealization and reality. These reflections should identify actions that could be enacted in similar situations in the future, offering

hopeful alternatives to the *status quo*. In this specific case, a discussion between the attending and student aiming to identify the oppressive forces influencing the situation, and how they could adjust the workflow to increase patient comfort and satisfaction, could have sparked change.

Pedagogy with learners as opposed to pedagogy on learners

A group of students, a resident, and a supervisor have just visited a patient with critical arterial obstruction in his left foot caused by heavy smoking. While they discuss the possibility of amputation, the supervisor says this could be the best treatment in the long run, considering it is more difficult to go on buying cigarettes jumping on one foot. Some in the group laugh, including a student who, afterwards, feels ashamed and guilty about it. She is comforted by the resident who explains that such jokes are harmless as they do not affect patient care and help to cope with the challenges of the medical practice.

Oppression as we see it

Throughout medical training, learners witness some of their role models mistreating and joking about fellow students, health professionals, and patients, discriminating against minorities, and imposing unbearable workload on subordinates.[5,6,12,41,42] In Wear et al.'s[5] *Making Fun of Patients,* medical students report jokes such as "if somebody comes in with an object lodged in their anus, that's entertaining," remark on unconscious female patients as having "fabulous knockers," and refer to a psychiatric ward as the "retard hallway." In Fuks'[41] *Joining the Club,* a student reflects on a situation in which a patient was called a "crazy bitch" by an attending. As learners search for a sense of belonging, situations like these usually carry an implicit pressure to conform. This alignment with peers at the expense of alignment with patients' best interest has been shown to trigger suffering .[11,40–42]

In this vignette, the students' guilt and shame shows that conforming oppressed her values of patient care. Such unprofessional attitudes are frequently legitimized as strategies to cope with stress and, unfortunately, perceived as the reality of the medical profession, beyond any possibility of change.[5,6,8] The belief that this reality of abuse cannot be changed creates a perception of hopelessness, which as previously discussed, is the ideal context for perpetuating oppression. How to counteract the powerful effect of this (not so) hidden curricular experience? Cultivating good professional behavior committed to respecting and protecting the dignity of patients and peers is not possible if learners are unable to identify and resist inappropriate behavior. It is worth reflecting on what pedagogy medical education has adopted to support learners in this process of professional resistance.[43]

Problematization

Teaching learners the *correct* professional attitudes is different from nurturing a true appreciation for professionalism. For CP, when learners are asked to reflect upon professionalism, and the outcomes of this reflection are defined *a priori,* it results in a pedagogy imposed on learners. This approach disregards their own perspectives and feeds them with teachers' viewpoints. The movement of stepping outside reality to subsequently return to it differently, empowered with hope and attitude for change, can only be authentic if accompanied by the freedom to imagine and enact alternative realities. These alternative realities should not be an act of one on the other, but an invitation to discuss and challenge oppression with each other.[26]

A pedagogy with learners acknowledges the intended outcomes while understanding that no outcomes are guaranteed. It allows learners to engage in meaningful conversations with their teachers in a dialogical process where disagreeing is perceived as conducive to transformative learning for both learners and teachers. Bringing that complexity to the table allows learners to understand that professionalism is not a fixed goal to be pursued, or a set of rules to be followed. Professionalism happens in the world and the most appropriate behavior cannot be predefined because it depends on context. Being a good professional is not easy and often requires resisting the system to keep faithful to ourselves and to honor patients. A pedagogy with learners is not prescriptive, it involves them in the discussion and stays open to their input, criticisms, and perspectives.[25,26]

The untested feasibility

In the context of our vignette, a pedagogy with learners would not simply place the resident's statement, "making fun of patients is harmless," into a "right" or "wrong" category of professional behavior. It would open a discussion to challenge this assumption in a dialogical process that embraces the complexity of reality, without canceling voices or avoiding the discomfort necessary for change. In Freire's words "No one can be, authentically, forbidding the other to be."[26] By acknowledging diverse perspectives and searching

for ways to actively align values and behaviors, learners can agree on collective untested feasibilities and assume a protagonist role in their professional development. In this situation, taking a moment to discuss her feelings of shame and guilt with a trusted person could offer new perspectives on how the student can remain true to her values of patient care.[44]

Education as a democratic relationship

A woman is shouting, demanding immediate care for her baby in the emergency waiting room of a poor community. A warning to calm down or leave had little effect. The supervisor does not disguise her discomfort with "the scene." She witnesses, at a distance, a medical student approaching and talking with the woman, who becomes calm. Amused, the supervisor listens to the student reporting on what happened: "I know her from my neighborhood. I told her I know we are not used to being heard unless demanding attention and that I am sorry for that. I reassured her that the baby will soon get the attention he needs." The supervisor, an upper middle-class woman who never had to raise her voice to get attention, cannot stop thinking how that perspective about patients' "inappropriate" actions had never occurred to her in all her years of emergency care.

Oppression as we see it

This vignette exemplifies how the dehumanization of impoverished people when Freire initiated his work persists. Poor people continue to have poorer access to health care,[45] and yet their behavior is frequently deemed responsible for their poor health care outcomes. Most health care professionals can remember "troublemaker" patients being mistreated as an explicit or implicit punishment for their "bad" behavior. Contrary to the previous vignettes, however, the situation of oppression toward the mother did not translate into oppression toward the student. It was mitigated by the student's empathetic and proactive mediation, which the supervisor embraced.

Problematization

CP understands that education happens in relationships, and all engaged can and should be affected by each other. For Freire, "there is no teaching without the learner."[25,26] After all, there is no such a thing as complete (finished) individuals or professionals. There is always something new to be learned. If a relationship with learners is built on trust, teachers learn, and learners teach. When this break in trainer-trainee hierarchy is explicit to everyone involved, it also becomes a powerful role model toward a break in medical-patient hierarchy, which ultimately nurtures patient-centered care. It is reasonable to assume there is a parallel between the power distance between doctors/patients and teachers/learners, as both carry power asymmetry.[46,47] To achieve patient-centered care and learner centered-education, this power imbalance needs to be actively changed by the powerful, doctors and teachers, supporting the empowerment of the powerless, patients and learners.[46] Certainly, this empowerment depends on patients and learners speaking up and coming up with their own agendas, but their transformative power is only fully realized when they understand how they can do so.

The tested feasibility

In the situation described, the student offered the supervisor a different and relevant perspective on behaviors perceived as disrespectful and inappropriate. One naïve perspective of the woman shouting is that she is an inconvenient and uneducated person who does not know how to behave in a health care facility. The student intervention, however, triggered in the supervisor a moment of epistemological curiosity, the curiosity that is not satisfied by simplistic explanations but searches for the complex factors underlying attitudes, contexts, and problems.[26] The student's perspective and attitude offered a moment of critical reflexivity,[23] which the supervisor embraced by being open and self-critical. She opened herself to be transformed by the student, understanding that attitudes and behaviors such as shouting in the emergency room is mediated by power relations and might have different, and legitimate, underlying causes.

Possible paths to exploring untested feasibilities

Different contexts will pose different challenges to achieving a better reality regarding abuse and oppression in medical training. New untested feasibilities are unique to individuals and groups and specific moments in time. We have searched for practical inspirations in history and in the work of fellow researchers that can support us, independently of our specific realities, in the pursuit for change. Individually, we can:

- *resist hopelessness*. Medicine has undergone significant transformations. Initially met with skepticism, these changes have now become the accepted reality from which we benefit. The integration of women into the medical workforce and the adoption of evidence-based practice are examples of positive transformations that inspire hope for additional change.[48,49]
- *acknowledge the oppressor in ourselves*. Everyone engaged in medical education is in a position of power in relation to others, be them more novice learners or faculty, other health care professionals or patients. Personal experiences of vulnerability can help one see him/herself in the oppressor and change. For instance, healthcare providers have reported that experiences as patients increased their perception of the relations of power in patient care.[50] Supervisors who take the place of learners in specific pedagogical interventions may experience the same transformation.
- *take the time to reflect upon uncomfortable feelings, such as anger and shame, triggered by an act of others or our own*.[44] Moral dilemmas have been shown to trigger intense and long-lasting emotional reactions.[40] Individually elaborating on these emotions with epistemological, as opposed to naïve curiosity can provide a sense of closure, reinstate well-being, and shape future practice.[40] Communicative learning, dialogue with a mentor, a trusted and more experienced other, can facilitate and improve this process.[44]
- *resist oppression while preserving individuals' well-being and careers*. The more vulnerable our position, the more careful resistance should be. Only we can understand the pain inflicted by oppression we endure, and only we can determine the risks we are prepared to take to address it and change our reality.[43,44]

Beyond individual actions, educational environments can also nurture a *praxis* based on CP by:

- *co-designing educational interventions with* learners*, inviting them to come up with their own learning goals and educational methodologies*. These interventions invite learners to adopt a different level of engagement and responsibility, while providing opportunities for educators to understand their needs.[51,52] These interventions can be even more powerful if educators allow learners to take the position of power and teach "the teachers."
- *co-creating spaces to "problematize" the hidden curriculum—safe spaces where learners can challenge the status quo and rehearse strategies to resist oppression*.[47]
- *adopting a culture of self-reflection and self-criticism, where supervisors role-model the process of reflecting on the clash between idealization and reality,*[39] *while sharing with learners a sense of hope and urgency to change*.
- *embracing, instead of dismissing, learners' acts of principled and ethical resistance*. In the hierarchy of power in medical education, learners are usually in positions of vulnerability. When they enact resistance to oppression, they are assuming considerable risks.[43] An educational culture coherent with CP requires stakeholders to absorb these acts respectfully. It also requires schools to support learners in differentiating professional and unprofessional resistance.[36,43]
- *promoting solidarity within the medical profession and across the allied healthcare professions*. The challenges faced by healthcare professionals are similar, however we seldom address these challenges together during undergraduate and postgraduate training. By creating opportunities to discuss these challenges together and learn from each other how to change oppressive systems, we can not only share unforeseen untested feasibilities but also generate a sense of belonging and resilience.
- *celebrating diversity*. A diverse health care workforce provides the best scenario to foster epistemological curiosity, as people from different social and cultural backgrounds can offer different perspectives about similar situations. Cultural humility, a *praxis* of awareness, respect, and flexibility toward power imbalances, can support the *praxis* of CP.[53,54]

Discussion

We have discussed how oppression and abuse have been a persistent reality in medical training, despite the professionalism movement within medical education. While recognizing the advances of those tested feasibilities in creating a new and improved reality, we understand that it is time to pursue new realities, one that challenges the hopeless perception of oppression as an unavoidable culture of medical training. We have proposed that CP can support medical training toward new untested feasibilities: (a) critical consciousness as *praxis*, (b) pedagogy with learners and (c) education as a democratic relationship. The understanding of

critical consciousness as *praxis* is much needed to promote cultural change. Critically reflecting upon the workplace and ourselves, pursuing a better understanding of who we are, the context in which we are, and who we want to be as individuals and professionals is undoubtedly relevant. Whatever the strategy to foster critical consciousness we choose to adopt in educational contexts, we should keep in mind that transforming medical education culture requires such reflections to be authentic and translated into action.

Authenticity can only be achieved if different perspectives are embraced in the problematization process and disagreements are perceived as opportunities for change both for educators and learners, an idea conceptualized by CP as pedagogy *with* learners. In CP, problematization does not lack intention, but acknowledges that its outcomes cannot be anticipated. Critical consciousness can only be nurtured, not taught. It is unrealistic to expect that the opposite, pedagogy imposed *on* learners, which disregards their values and beliefs, will counteract the powerful forces within and outside medical training that influence professional and personal development. By recognizing these complex dynamics, we can strengthen the development of critical consciousness.

Critical consciousness, in turn, can reinstitute hope for change as it situates oppression in the context of systems and individual power relations that can be challenged, revealing new untested feasibilities that can be pursued. Nurtured among educators, critical consciousness can expand learners' experiences with positive role-models. When nurtured among learners, it can support them in dealing with the inevitable dissonances between the idealization and reality of medical practice. Within one's emotional, political, cognitive, and ethical reach, acts of advocacy and resistance that break the chains of oppression can translate critical consciousness into *praxis*.

The third principle of CP presented and discussed in this paper is what sustains the others: education as a democratic relationship based on trust. A pedagogy with learners toward critical consciousness is only possible if the educator-learner hierarchy is challenged, and if the educators see themselves as incomplete individuals and professionals who can learn from experiences with learners and patients. It does not mean that CP is opposed to the regulations that place the ethical commitment to patient care above our own perspectives and beliefs.[10,43] On the contrary, it calls on educators to use their authority to counteract oppression.[25] What CP opposes is authoritarianism.

Finally, a limitation of this essay is not addressing the fact that oppression affects learners differently. Racial and gender differences, for example, are not discussed but should be acknowledged by educators and schools when planning strategies to counteract oppression.

Conclusion

Medical education can find inspiration int the principles of CP to try new untested feasibilities toward a culture of dignity for all patients, learners, and educators. It is a movement that has already started, with relevant achievements, and demands continuous renovation as long as the culture of abuse and oppression persists. Conforming with new realities, however better than previous ones, is not enough.

Author notes

Ligia Ribeiro contributed to the conceptualization of this paper. She wrote the initial draft of this manuscript, edited revised versions and approved the final version.

Marco de Carvalho contributed with the conceptualization of this paper. He reviewed and edited the initial manuscript and its revised versions and approved the final version.

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