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WHEN I SAY

When I say… travelling concepts

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A large part of doing medical education research consists of working with concepts. The papers in this section of *Medical Education* are usually devoted to discussing one such concept. However, what about the often unquestioned concept of 'concept' itself—a question that depends on the discipline and the underlying assumptions that tension it.[1] For example, in cognitive psychology, concepts are often seen as disembodied, abstract ideas—as 'constructs'. They live apart from language and perhaps even apart from thought. However, this is not how we look at concepts. We see them as critical friends, each with their own history and personality that also demand consideration. Far from abstract entities, they are our analytical tools, shaping the frameworks that allow us to engage in a meaningful dialogue with our objects of research. Here, we specifically mean *travelling* concepts—a tool for interdisciplinary analysis introduced to the humanities by Mieke Bal.[2,3] It is useful for medical education as well, which is also an interdisciplinary (or at least, multidisciplinary) field.[1]

Concepts are first of all words. A word can become a concept via its systematic use and development. As an example, consider the word 'depression'. While it can mean either a mental 'disorder' in psychology or a 'low pressure system' in meteorology, both uses of the concept draw upon the word's etymology—*deprimere*, 'to press down'. But the concept is also used in everyday language in a looser sense—people say 'I am depressed' when they feel sad. Much of the work of medical education, medical education research, and indeed this series, is to distinguish concepts from mere words. Especially when speaking with colleagues from different disciplinary backgrounds, we should always clarify what we mean when we use concepts.

Yet, even concepts that are well established in medical education have followed an extended trajectory to reach that point. During their travels, they both acquire and shed 'baggage' along the way. For instance, the concept of 'reflection' travelled from philosophy to psychology, thence to educational science. Similarly, the concept of 'evidence' has a very specific meaning in mathematics, but was adopted by medicine via the natural sciences, finally finding a home in medical education research. Hence, it necessarily brings with it baggage, such as the idea that the randomised controlled trial is the gold standard—also for medical education research. Such concepts quickly become concrete when you map their 'travel histories'—the ways in which they have been systematically put to work in different (academic) cultures, communities and contexts.

Finally, concepts have boundaries and affordances or 'preferences'—what we can (and cannot) do with them. Only when we distinguish concepts from mere words and map their trajectories can we start to explore how we can work with them in our research. Consider again the concept of evidence. This concept is at the intersection of a fundamental debate between positivism, which is at the root of medical science, and approaches from the human sciences such as phenomenology and constructivism. Positivism sees evidence as something that is found rather than generated. Facts established in the research process are seen as the basis for the undisputed existence of certain phenomena, objects or relations. However, working with concepts involves a different view of concepts and evidence. Here, conceptual tools *establish* phenomena, as much as phenomena *invite* particular concepts. This is why, in medical education research, we cannot say that themes 'emerged' from the data or that evidence was 'found' for the effectiveness of a certain intervention. Concepts themselves are not stable entities that are found 'out there' or that are constructed once and for all—they can (and should) change and evolve. The particular concepts that we use determine how we view education, our research objects and research.

Yet, what exactly is revealed about medical education when we reflect upon the historical backgrounds or disciplinary groundings of the concepts that we use? Further, what does their use in medical education reveal about such histories and about knowledge and insights gleaned from other disciplines? Returning to the

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example of reflection, the concept has until recently been seen primarily as a metacognitive process. However, it is increasingly seen as an embodied, situated phenomenon that involves the whole person, not just the mind. The meaning of a given concept reveals itself in the use made of it, and hence, it has multiple valid meanings. Thus, concepts can facilitate academic discussion and rigorous research if we take them as a starting point—a common ground on the basis of which we can discuss our differences and commonalities.[3,4] Concepts become productive forces 'not because they mean the same thing for everyone, but because they don't'[2(p.11)] For example, a careful unpacking of the layers that make up the concept of 'evidence' opens for debate questions as fundamental as the very nature of teaching. Biesta and Van Braak show that the concept of 'evidence' as used in *medical* research, cannot be applied to medical *education* research, because it carries with it causal assumptions that work in the medical model, but are inconsistent with the nature of education.[5]

Hence, the power of a given concept is not to be found in the degree to which we can rigidly define it so that once set, it can be straightforwardly applied to practice. On the contrary, it is in the degree to which concepts *resist* such straightforward application that they become our conversation partners. Finding our methodological basis for educational research in concepts rather than theories would allow us to turn our focus to the practice of medical education in a similar way to patient-centred care in medicine. Rather than approaching the object of our research armed with predetermined categories, we engage instead in a dialogue in which we respect the object's boundaries and affordances. In this dialogue, the object is allowed 'to speak back'[2(p.45)] and we can adjust the concepts with which we approach it accordingly. Therefore, working with concepts demands that we tailor our methodological approach to the object of research—to listen to it first, only then choosing theories and methods so that the object is allowed to reveal itself on its own terms.

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