CHAT researcher profile: Professor Alan Bleakley

Who am I?

Emeritus Professor of Medical Education and Medical Humanities at Plymouth Peninsula Medical School, Faculty of Health, University of Plymouth UK. My academic background is in Zoology, Psychology, and Psychotherapy. I practiced for many years as a psychotherapist. I retired from full-time work as Head of medical education research, Peninsula Medical School UK, and now write and give talks. I have written or edited 20 academic books and many articles and book chapters. I am also a widely published poet with six collections. One of my passions is surfing – for 60 years, starting when I was 15, and still loving it despite older age!

The values that have shaped my work

As a lifelong socialist, my academic career has been focused on research and scholarship that creates conditions for social justice. As a poet and writer, I am naturally drawn to ethics and aesthetics. My work has attempted to fuse politics, ethics, and aesthetics. Inspired by Peter Weiss' novel *The Aesthetics of Resistance,* I encourage medical students to form identities of resistance to historically ingrained habits of medical culture, typically masculinist and authoritarian. The work of the Curriculum Reconceptualists (such as William Pinar) - linking ethics, aesthetics, and politics through reading curricula as value-laden texts - has long inspired me. In my curriculum development work I emphasise the value of curriculum as process that shapes identities, beyond syllabi as solely informational.

In the 1960s, studying psychology, I was drawn to cultural-historical dimensions to cognition, against the grain of the focus at the time upon the individual. Later, I came across the work of the American cultural psychologist Mike Cole who had studied in Russia, and then Yrjö Engeström's work. In the latter, I saw a project with democratic intent. While developed initially in work contexts other than medical education, I could see how CHAT could be applied to medical pedagogies.

Directions in my work

I live and work by the maxim that we can learn from the past and aim for the future but should not instrumentalise the present. Also, we should not strive for heroic individualism in the face of the good of the collective. My Zoology background brought two influences: Adolf Portmann, who urges the primacy of form before function or appreciation before explanation; and Jakob von Uexküll, who focuses on what the *umwelt*, or immediate environment, affords perception. Such models mesh neatly with current work on clinical diagnostics suggesting that doctors' cognitions are extended beyond the brain, distributed, and context-sensitive (situated). From Actor-Network Theory, I have learned how artefacts (as actors themselves) circulate through a web of actors and are given differing meanings and values in differing contexts, and from Object Oriented Ontology (OOO) how artefacts may be given the same ontological status as persons. These perspectives enrich CHAT. In my current work on metacognition (thinking-about-thinking) I have been interested in how medical students and doctors manage meta-affect (gaining insight from catharsis). This returns me to my work from two decades ago on reflective, reflexive, and refractive practices. I think that the key to effective boundary crossings is not structural (rules such as protocols and guidelines – commonly used in medicine), but meta-structural - as refractive practices or dialogical activities that may eschew protocols (evidence-based practice or guidelines) for what Gabbay and LeMay call 'practice-based evidence' or 'mindlines'.

Research and scholarship work in medical pedagogy

In the late 1990s, after an academic career devoted largely to developing postgraduate psychotherapy education programmes, I moved into medical education. My first empirical research projects in this field were

focused on: (i) senior doctors teaching juniors on ward rounds in multi-professional team settings; and (ii) improving work patterns for surgical teams. Both activity settings attracted CHAT as an informing, exploratory and explanatory model. Individuals with differing skill sets and histories (roles/ division of labour), working with common rules in a community and drawing on a range of artefacts adopted a common outcome (patient care and safety). Key to effective patient care and safety, and to team member satisfaction, are democratic habits. Yet clinical teams I studied typically had adopted historically conditioned hierarchies. I adopted an interventionist approach drawing on modified change laboratory methods for transforming work. I introduced analysis of videotaped examples of both ward teams and surgical teams at work through a collaborative inquiry model. This was backed by an extensive set of staff development interventions. The explicit political aim of both interventions was to change values in clinical education settings from autocratic-hierarchical modes to democratic-dialogical modes. This proved successful particularly for surgical teams, where democratic briefing and debriefing protocols were introduced, and surgeons were taught to change their habitual prescriptive interventions to dialogical and facilitative patterns. The research found that inter-team surgical communications proved to be more critical to patient care and safety than intra-team activities. Thus, the frame for the work evolved to look at facilitation of boundary-crossing activity (as expansive learning) where this was mostly frustrated by historical conventions (leading to collapse of potential expansion or crystallisation of activity).
Medical education research has lagged behind many other fields of research and scholarship, bound by conservative tradition, often grounded in individualistic, psychological models. Thus, as far as I know, so-called 'social learning theories' (rather than individualistic models) were not introduced into medical education until 2001/2002 (Bleakley 2002, 2006) and not fully articulated until almost a decade later (Bleakley 2014, 2021). Despite the work of Professor Tim Dornan and myself, CHAT has still not gained traction in UK medical education, although it is clearly fit for purpose as an exploratory and explanatory framework.
Subsequently, I have led a range of clinical education research and scholarship activities, particularly in the field of medical humanities. Amongst these are empirical studies of use of the senses for decision-making in doctors and artists; storytelling as a means of democratising psychiatric practice; and 'proof of concept' studies for developing a poetic imagination in medical students and doctors to enhance diagnostic reasoning and communication capabilities with an emphasis upon the value of metaphor production.

Selected CHAT-related research and scholarship

Bleakley A. Pre-registration house officers and ward-based learning: a 'new apprenticeship' model *Medical Education.* 2002;36:9-15.
Bleakley A. Broadening conceptions of learning in medical education: the message from teamworking. *Medical Education*. 2006; 40: 150-57.
Introduces sociocultural learning theories, including CHAT, to a medical education audience still grounded firmly in individualistic learning models ('adult learning theory'). Argues that, if medical practice occurs in and between teams working around a patient, then learning can only be explore and explained as sociocultural.
Bleakley A. The proof is in the pudding: Putting actor-network-theory to work in medical education. *Medical Teacher*. 2012; 34: 462-67.
As part of the nest of sociocultural learning theories, ANT is considered particularly for its research advice of 'dig where you stand' and its consideration of the value of material artefacts in expansive learning.
Bleakley A. 2014. *Patient-Centred Medicine in Transition: The Heart of the Matter.* Dordrecht: Springer.
Considers a nest of theoretical perspectives that all medical educators should be familiar with when theorizing team process: CHAT, Foucauldian power dynamics, ANT, Deleuzian rhizomatics, and complexity theory.
Bleakley A. Re-visioning clinical reasoning, or stepping out from the skull. *Medical Teacher*. 2021; 43: 456-62.
Considers models of extended and situated cognition in the context of clinical reasoning, as parallel models to CHAT.
Bleakley A. Embracing ambiguity: Curriculum design and activity theory. *Medical Teacher*. 2021; 43: 14-18.
CHAT was used as an informing framework to develop an innovative curriculum in a new medical school – Peninsula Medical School UK – launched in 2002.
Bleakley A. 2021. *Medical Education, Politics and Social Justice: The Contradiction Cure.* Abingdon: Routledge.
Politics (power structures) are integral to medical practice. Medical education should attend to teaching the political dimensions to medicine. Specifically, CHAT can inform thinking about expansive learning through medical education that takes account of both sovereign and capillary power structures and processes.