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WHEN I SAY

When I say … essentially contested concept

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1 | INTRODUCTION

Imagine a championship with no scoreboard. Teams compete, but victory is not decided by points. It's judged by "playing the game best." Each team has developed its own distinctive style, and each faction of supporters insists that their team embodies what the game truly is.

They argue with evidence and passion. They rarely converge.

The philosopher W.B. Gallie invented this strange thought experiment in 1956 to illustrate the "essentially contested concept".[1] Now consider a curriculum committee debating "integration," an accreditation body defining "competence," or a faculty meeting on "professionalism."

We argue with evidence and passion. We rarely converge.

2 | WHAT MAKES A CONCEPT ESSENTIALLY CONTESTED?

Gallie challenged a common assumption. We tend to treat conceptual disagreement as a problem to be solved with sharper definitions or better data. He argued that for certain concepts, disagreement is a defining feature, not a defect. The endless dispute over proper use is what the concept *is*.

Not every contested concept qualifies. Gallie specified criteria. The concept must carry value; it has to matter, to have stakes. It must be complex enough that reasonable people can weight its components differently. It must stay open to revision. And disputants must share an original exemplar (a common ancestor each claims to represent truly) while knowing they disagree.

This is why an essentially contested concept differs from a *vague* or *confused* one. Precision cures vagueness; analysis resolves confusion. But essential contestation is structural: to legislate a single correct definition does not clarify the concept; it impoverishes it, stripping away the normative richness that made it matter.

3 | WHY THIS MATTERS FOR MEDICAL EDUCATION

Essentially contested concepts saturate medical education: competence, professionalism, well-being, leadership.

We treat these as technical problems awaiting better tools: convening consensus conferences, writing reviews, building rubrics and milestones, as though sufficient effort will finally pin down what concepts like 'professionalism' mean. This impulse is not accidental; medicine rewards certainty and treats ambiguity as a deficiency, so when it meets a concept like 'professionalism', the reflex is to operationalise it. But some concepts resist resolution by design – not for want of effort, but because of what they are.

Consider *professionalism*. Systematic reviews reliably conclude that no consensus definition exists.[2] Researchers typically frame this as a problem to solve. But viewed through Gallie's lens, the proliferation of definitions does not mark failure; it reflects the concept's internal structure. "Old" professionalism emphasised detachment, autonomy, and self-regulation. "New" professionalism emphasises

collaboration, transparency, and social accountability.[3] Both camps claim Osler as ancestor. Neither is empirically wrong; they weight the components differently.

Why is professionalism contested? Because its central disputes turn on competing ideas of 'good' – autonomy against accountability, self-regulation against public oversight, ultimately what the profession owes society.[3] Ranking such 'goods' is a moral judgement, not an empirical finding, so rival accounts can differ without any being mistaken; the concept is internally complex, not ill-defined. Such disagreement is not cultural variation or institutional fashion; these are symptoms of the contest over goods, not its cause. No systematic review can resolve a question of value, which is why multiplying definitions has not produced consensus and could not. As recent work argues, such contestation is itself part of how standards are made.[4]

Or consider *competence*, now a 'product' in medical education.[5] Competency-based frameworks attempt to de-contest it, fragmenting it into observable, assessable units: Entrustable Professional Activities, milestones, behavioural markers. Yet their architects intend rich, judgement-laden assessment, not mechanical box-ticking; the danger is not the framework but its reification, when one conception hardens into the concept and we optimise for the proxy. Critics still counter that something essential is lost[6] – the emergent quality of judgement, the capacity to handle the unknown, the integrated identity that makes a physician more than a skill set. Data cannot resolve this quarrel. Both sides are playing the game; they disagree about what playing it well looks like.

4 | IMPLICATIONS FOR PRACTICE

If *professionalism* and *competence* cannot be pinned down, what follows? Recognising them as *essentially contested* will not end disputes; it will change how we engage them.

4.1 | Teach the contest, not just the content

Rather than handing students a professionalism checklist, teach them why professionalism is debated. Equip them to navigate ambiguity and to recognise heterogeneity, not memorise a code that will shift beneath their feet.

4.2 | Practise assessment humility but still decide

Any rubric for an essentially contested concept captures a conception, not the concept. Yet educators must finally judge a trainee competent or not. *Essential contestation* forbids only the pretence that this judgement is value-free. None of this is costless, but in practice it means triangulating assessments, making the working conception explicit and revisable, weighting expert judgement alongside scores, and treating thresholds as defensible commitments, not discovered truths.

4.3 | Diversify the definers

Those who decide what counts shape the concept, so excluding voices has both epistemic and ethical consequences. Bring patients, trainees, and dissenting clinicians into defining the concept.

4.4 | Embrace productive tension

Gallie argued that competition between rival uses sustains and develops the tradition from which a concept derives. The goal is to keep the debate progressive, pushing the profession forward rather than calcifying around one faction's exemplar.

5 | CONCLUSION

Back to the championship without a scoreboard. The endless competition between teams, each claiming to play the game best, is what keeps the game alive. Our view is that medical education's long pursuit of consensus definitions for its core concepts is largely a misdirected effort; the task is not to end the contest but to learn to compete within it well.

When we say "essentially contested concept," we mean this: there is no scoreboard, and that is not a defect. It is what keeps the game worth playing.

AUTHOR CONTRIBUTIONS

Matthew Bowker: Conceptualization; writing—original draft. **Michael Atkinson:** Writing—original draft.

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The authors report there are no competing interests to declare.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ETHICS STATEMENT

This is a theoretical piece and exempt from institutional ethical approval.

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