

Resculpting Professionalism for Equity and Accountability

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ABSTRACT

Recent controversies over the characteristics of “professionalism” and its enforcement by medical educators underscore the racialized and gendered norms implicit in this practice. In this essay, we describe the ways nebulous definitions of “professionalism” imbue White, cisgender, straight, and able-bodied standards to police the boundaries of belonging in medicine. As such, marginalized trainees remain unfinished sculptures, forced to chisel away dimensions of experience and expression to conform to “professional” standards. We seek to resculpt professionalism in a way that centers patients and trainees currently at the margins. This will strengthen the increasingly diverse workforce and ensure that they can effectively address the needs of patients often excluded from quality care.

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“A patient of mine whom I had not yet met,” the white coat ceremony speaker began, “once walked up to me and said, ‘Hey Doc!’ When I asked him how he knew I was his physician, he told me, ‘You just look like how a doctor should look.’”¹

The speaker’s anecdote intended to showcase the power of the white coat as a symbol of the medical profession, a means to secure a patient’s trust. As a straight, cisgender White man, this was his reality. However, we have been told candidly (and in code) throughout our medical training that we do not belong in the field. We—an Italian-Chilean mother, Black woman, White lesbian woman, Black man, and Black trans woman—must reach much farther than a coat hanger for affirmations of our professionalism. For us, it is not enough to show up on time, don our white coats and stethoscopes, and invest our knowledge and humanity in the service of our patients. Often, we must also polish our speech, carve our bodies and dress, and sever parts of our lives to meet the “professional” expectations our mentors and patients set for us.

In this Reflection, we describe the loss that marginalized trainees undergo to comport with the racialized, gendered, and embodied norms of professionalism in medicine. We further propose a new standard for professionalism, one that centers the trainees on the margins, emphasizes competencies most relevant for patient and community well-being, and challenges hegemonic conceptions of the ideal physician.

DEFINING PROFESSIONALISM IN MEDICINE

The Accreditation Council for Graduate Medical Education’s (ACGME) definition of professionalism requires that physicians “presen[t] themselves in a manner befitting of a societal caregiver” and “trea[t] all people with respect and dignity.”^{2,3} The ACGME Core Competencies for residency reference “professionalism” 17 times, emphasizing role modeling by program directors and faculty, ethical behavior, responsibility to other members of the health care team, and competing objectives of “self-care” and “effacement of self-interest.”³ Though the ACGME focuses this competency on high-quality and equitable patient care, supervising physicians within an exclusionary health care system have used this nebulous definition to police racially minoritized, femme, transgender, gender-nonconforming, and disabled bodies.^{4,5}

Family medicine defines professionalism as maintaining standards of competence and integrity in full service of patients. Physicians should accept responsibility for

learning and maintaining standards of discipline, and self-regulate lapses in ethical standards while navigating their own well-being alongside the competing needs of their patients and their patients' families.^{6,7} With physicians and students from marginalized backgrounds and upbringings that run contrary to dominant cultural norms, supervisors may view that process of negotiation unfavorably; as such, supervisors may consider trainees' judgments about building rapport and personal care "unprofessional." We see this particularly in feedback given to Black resident physicians regarding the tone of their voice, body language, and even use of African American Vernacular English (AAVE) when speaking with patients of similar backgrounds (Table 1).

Multiple studies—including a now-retracted and widely criticized article assessing social media use among vascular surgery trainees that launched the ironic hashtag #MedBikini—have attempted to characterize the elusive standards of professionalism in medicine.^{8,9} Behavior and presentations classified as unprofessional or undesirable included wearing Halloween costumes, drinking alcohol, and, yes, posing in bikinis on social media.⁸ In a study of applicants to dermatology residencies, those who submitted photographs were more likely to match and, among those, women were more successful if they wore collared shirts, shoulder-length hair, and blazers whereas no difference was found among men based

on grooming or attire.⁷ These patterns expose biases against women, queer people, and racially minoritized people whose authentic presentation (eg, androgynous, kinky or coily textured hair) may not align with White standards of beauty.

RACIALIZED AND GENDERED NORMS OF PROFESSIONALISM IN MEDICINE

Despite the ACGME professionalism competency of "treating all people with respect and dignity"² and the Medical Professionalism Project principle of "social justice"¹⁰ and the family medicine norms of considering patients' social and community context, medicine has a longstanding history of exclusionary practices on the basis of race and gender. As far back as the 1600s, physicians in what would become the Americas safeguarded the economic value of human cargo on the Middle Passage and abetted the practice of human enslavement: surgeons aboard ships carrying human cargo commonly blamed death and disease of enslaved Africans on "melancholia" or "sickly" constitutions, rather than on starvation, water restriction, inadequate sanitation, and forced crowding so that individual bodies "had not so much room as a man in his coffin."¹¹ In the 19th and 20th centuries, physicians embraced the scientific racism of eugenics, exploiting their training to advocate for stricter immigration policies and reproductive

Table 1. Minoritized Trainees' Experiences¹⁹ of Unprofessionalism

Professionalism Domain	Trainee	Trainees' Experiences	Axes of Oppression Upheld
Disrespectful communication	Black man	"On my pediatrics rotation, I met a Black family whose child was meeting all their developmental goals. I said this was 'lit' and the family agreed. Later my resident told me this was 'unprofessional.'"	Racism
Disrespectful communication	Black man	"I was given feedback after a 2-week family medicine inpatient rotation. I was told I performed excellently, however there was concern that the way I speak and my body language during rounds brought down the morale of the group. I was asked to smile more and speak more softly and assigned faculty from the psychosocial department to help me do so."	Racism
Limited availability	Latina woman	"I asked for permission to miss my pre-clinical clerkship to accept an award on behalf of my school's Student National Medical Association chapter. Peers of mine had missed to attend academic and clinical conferences, so it didn't seem like a big deal, especially since we were receiving a national award. I had missed once before due to chronic migraine but thought I was in good standing. After sending my request, I was called in to speak with the director about 'professionalism,' and they told me my absences were excessive and unjustified."	Ableism Racism
Lack of initiative	Latina woman	"I was deemed unprofessional once for considering missing a clinical skills opportunity that involved a 30-minute and \$65-dollar round-trip Uber ride because my car was in the shop. When I responded that I was experiencing financial and mental stress, which was why I was considering missing the session, the faculty member never responded to my email. I still feel stress any time I run into this faculty member."	Ableism Economic inequality
Lack of self-awareness	Black woman	"During a clinical skills debrief of a pediatric emergency simulation, a White pediatrician led a panel of faculty to evaluate and provide feedback for the 4 student (2 Asian men, and 2 Black women) participants. Over the course of a half hour, [the evaluator] repeatedly attributed the clinical suggestions and contributions of the Black women to the men in the group. The 2 Black women received feedback asking them to take notes from their [male] classmates who demonstrated 'leadership' during the simulation."	Racism Sexism

control,^{12,13} and partnered with the Ku Klux Klan offering to perform castrations on Black men targeted for rumored sexual relationships with White women.¹⁴ Physicians, including family physicians, benefitted from urban renewal (or better, “removal”) projects that displaced Black and Brown families from “blighted” areas surrounding hospitals and academic centers, robbing them of wealth. Physicians—historically and recently—forcibly sterilized racially minoritized and disabled women.¹⁵ Physicians continue to withhold pain medication from women and racially minoritized individuals, engage with Black patients with more physical distance and fewer positive nonverbal cues, and celebrate superficial efforts to dismantle institutional racism rather than leveraging cultural, social, and financial capital to promote justice.^{16–18} Women and Black practitioners were barred from medical training and membership in the American Medical Association, and racially minoritized medical trainees continue to confront systemic barriers to medical school admission, encounter ongoing discrimination during training, and achieve less recognition for their achievements.^{19–21} Success in medicine requires assimilation into a culture of White supremacy that harms minoritized trainees.²²

The apprenticeship model of medical education—by which more senior physicians model practical and behavioral standards for trainees to emulate—further reinforces hegemonic ideals. Professionalism implicitly describes the cultural norms, behaviors, and characteristics of the dominant social group: in medicine, this historically refers to straight, cisgender, able-bodied White men. Professionalism is therefore a competency on which only racially minoritized, femme (of either trans- or cisgender experience), gender nonconforming, and disabled trainees are evaluated. In other words, professionalism is our problem, not theirs.

PROFESSIONALISM AS POLICING

A recent study of 3,600 evaluations of 703 internal medicine residents found that Black, Latine, or Native residents were scored significantly lower on metrics of professionalism. In particular, men faculty rated racially minoritized residents 0.13 points lower than White residents in professionalism competencies.²³ These findings highlight the unconscious imbue of racialized and gendered standards in assessment of professionalism.

Although this assessment of graduate medical education evaluation did not further probe into the nature of professionalism lapses, a study of professionalism conducted at 93 medical schools found that most commonly remediated behaviors included “disrespectful communication (by e-mail or in person), inappropriate use of social media, and poor availability” as well as “lack of self-awareness (including of one’s limitations), lack of initiative, and being defensive to feedback.”²⁴ Labeling these acts as “unprofessional” may disproportionately target oppressed trainees for whom social and structural barriers may contrive how their choices are understood. In

Table 1, we feature anonymous narratives from minoritized and otherwise oppressed trainees—provided voluntarily on request and included here with permission—that offer examples of how perceived lapses in professionalism may impact trainee careers and obfuscate student strengths with respect to patient-centered competencies.²⁵

We argue that “professionalism” serves as an intentionally opaque catchall to hinder access to the advantages afforded through medical training and group membership.²⁶ In that same study of professionalism lapses among medical trainees, remediation efforts rarely targeted relationships with patients,²⁴ suggesting prioritization of informal “backstage” and “offstage” socialization into the medical profession, rather than “onstage” patient- and community-oriented conduct.²⁷

Further evidence of the inequitable application of professionalism standards surrounds common “offstage” complaints about faculty, particularly those in surgical fields. Students and staff frequently observe high-level faculty making derogatory or demeaning remarks about trainees, exhibiting outbursts of frustration (sometimes to the point of throwing dangerous surgical instruments), and engaging in academic misconduct. One student reported that a gynecologic oncologist repeatedly asked a PGY2, “Are you blind?” because the trainee did not position the laparoscopic camera the way the attending desired.¹⁹ Even as esteemed faculty engage in sexist, ableist, racist, and otherwise discriminatory behavior, repercussions rarely adversely impact their careers.²⁰ Those who wield power in medicine do not surveil unprofessional behavior among their colleagues²¹; as such, the exercise of evaluating professionalism serves to police the boundaries of belonging in medicine.

RESULPTING PROFESSIONALISM

We call for standards of professionalism that truly adhere to the fundamental principles of patient welfare, patient autonomy, and social justice, rather than as tacit barometers of belonging or exclusion (Table 2). Our proposed standards allow for bidirectional feedback on professionalism to foster safe, inclusive environments for historically and contemporarily oppressed and excluded populations on both sides of the caregiver-patient relationship. The face of the medical profession is changing, and the archetypal physician is no longer a White cisgender man in a suit. Yet, minoritized trainees persist under the expectation that we will carve away aspects of ourselves in a futile attempt to approximate this idealized version of “professional.” We remain unfinished sculptures, navigating medicine as fragments of ourselves, forced to chisel away the perspectives, expressions, and experiences that make us who we are to conform to the career to which we are called.

Professionalism must explicitly valorize patient-centered practices that enable access to care for marginalized patient populations and that accommodate the varied life experiences, views, and physical expressions of trainees.

Table 2. Proposed Pillars of Professionalism for Equity and Accountability

Pillar of Professionalism	Key Points	Example of Equitable and Accountable Approach
1. Patient-centered care	<ul style="list-style-type: none"> • Assessments of professionalism should relate directly to safe and ethical patient care. • Physicians should engage structural humility, particularly with marginalized patients.²⁹ • Physicians should attend to how their own subjectivity, positionality, and countertransference can bias their perception and behavior. 	<p>Situation: A Black medical student sees that a Black child has met all their developmental goals and comments, “that’s lit.” The supervising resident tells the student the behavior was unprofessional.</p> <p>Alternative: The supervising resident should consider how cultural, generational, racialized, and gendered differences in experience might shape their interpretation of the interaction. The supervising clinician should reflect on how the comment shaped the clinical encounter prior to making assessments about professionalism.</p>
2. Inclusivity and accountability	<ul style="list-style-type: none"> • Clinical teams should value the diverse contributions of each member based on both training (ie, rank, profession) and lived experience. • Physicians should center mutual trust and effective communication to optimize patient care.³⁰ • Individual professionalism should include honesty and accountability for colleagues. 	<p>Situation: A surgeon working with a resident in a laparoscopic procedure needed adjustment in the camera position and yells at the resident holding the camera, “Are you blind?!”</p> <p>Alternative: As valued as clinical team members, residents and technicians should be empowered to call attention to this behavior and encourage the surgeon to engage more positive skills to cope with stress.</p>
3. Equity	<ul style="list-style-type: none"> • Physicians should seek to dismantle racism, sexism, economic inequality, and other forms of oppression within medicine as an institution.¹⁰ • Assessments of professionalism should promote justice for minoritized trainees. 	<p>Situation: A disabled student of color with 1 excused absence for chronic illness requests another excused absence to attend a conference on leadership for racially minoritized students in medicine. The supervisors lecture the student on professionalism and excessive absences.</p> <p>Alternative: Institutions should provide disabled students of color with accommodations, and time and funding to accept an award at a conference that would promote their professional development.</p>

Race-agnostic definitions and general summons to “respect all” permit intrusion of the dominant, gatekeeping perspective of professionalism.²⁸ As we reimagine professionalism, we must center the margins, focusing on the populations most often excluded from medical practice so that we among the increasingly diverse physician workforce can present our full selves as we care for our patients.

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