

Diversity and Professionalism

Jennifer Tsai, MD, M.Ed
Rahil Rojiani, MD

Introduction

Professionalism and diversity have historically intersected at many levels and in widely different contexts. Indeed, the issue of diversity can be conceptualized as more of a perspective—one that can and should be considered and applied to multiple axes and considerations—rather than as a single topic of discussion. The complexities and nuances to diversity and inclusion fundamentally involve comprehension of historical legacies of supremacy, decolonization, and power dynamics. These require nuance and rarely have clear binary answers. We therefore choose to address this without defining right and wrong; rather, we seek to engage the reader by challenging the standards that society—and the medical profession in particular—has imposed upon itself. This chapter asks learners to embark upon a journey that explores how we characterize the standards of work culture, in order to interrogate what has become normative in our understanding of professionalism. In this way, we can more clearly ascertain what norms have been constructed, who has been able to construct them, what powers continue to perpetuate their stronghold, and their validity as self-imposed principles. This aids in analyzing which identities have been relegated to the status of “unprofessional” or “impermissible” and the inequities that arise and persist because of these very dynamics. Fundamentally, we ask learners to redefine professionalism in the context of a decolonial and diversity lens, and not the other way around.

Traditional medical education historically imposes the notion that biomedicine and clinical practice are apolitical objective disciplines rooted in fact and evidence. Trainees are encouraged to be identity-less, that is, to embody the assumption that the identities they bring—be it regarding race, socioeconomic status, ability, religion, gender identity, sexual orientation, or age—are inconsequential and irrelevant to the provision of medical care. Indeed, this inculcation may even imply that subjectivity is disavowed; bringing individual identities to a clinical field may be framed as harmful in its clouding of impersonal logic.

Stripping individuality from physicians is not only undesirable—for medicine is a social field mobilized through human actors—it is impossible. Any attempt to frame medicine as possibly separate from individual

identity will fail or be inaccurate. Furthermore, individual experiences prove to be assets in shaping compassion, understanding, and empathy. As the world changes from one where physicians are assumed to share common identities to one of a more diversified nature, we find that we have constructed professionalism in such a way that instead of centering ethical practice, our paradigm of professionalism in fact polices appearance and behavior as an assumed representation and proxy of a person’s ethical code and competence. This comes at the expense of the well-being of those who have diversified medicine by fighting against their unconscionable historical exclusion in the field.

We begin with an exercise: Imagine a room of professionals. They are wearing professional attire, behaving professionally, speaking in professional language and in professional tones. What manifests in your mind? What would a Google image search of this idea reveal?

With each of these questions, pause and genuinely consider: What do these individuals look like? What race and gender are they? What hairstyles do they have? Style of clothing? Who has piercings, and what kind of jewelry? Are any of them in wheelchairs? How are they sharing in conversation? How are they expressing emotion?

What is apparent in the scene? What is missing? It is apparent that we can conjure and recognize a picture of professionalism, but defining its “phenotype” is more complicated. It’s an intuitive feeling, an “I know it when I see it” concept. Professionalism, in our minds, has been constructed and taught in our lives through a series of lessons—both conscious and unconscious. It looks different within other rooms, across borders, among different people. And the question becomes, who gets to decide?

Professional Appearance

What constitutes a “professional” appearance? In this image of what a professional looks like, we might explore a number of possibilities, particularly along various lines of human difference upon which value is given or not: race, gender, class, body size, ability, and religion.

Reflecting the demographics of the medical professional world, this imagined room is likely mostly white, male, and able-bodied. These individuals walk to and fro without assistance, they are not accompanied by oxygen tanks, beeping machines, or walkers. They speak with their mouths not their hands, without stutters, without pause. They are upright and clean. Perhaps they are dressed in suits, crisp trousers, patterned ties. They do not need help getting dressed. They do not need help using the restroom. There is no sign of poverty or emotional despair. They speak in technical jargon, avoid colloquialisms, and modulate their emotions without a sweat.

It is unlikely that most hospital or medical administrators would devise this scene with individuals draped in saris or dashikis—regardless of how formal this attire is considered in its home culture—or of an individual visibly adorned in ink. Hair is likely short and well kept for men. No bright colors, no braids or afros. Men wear masculine clothing, women aren't showing too much skin. Everyone dresses and behaves as expected of their sex at birth.

This picture is the ideal that defines the norm. The picture we conjure becomes the appropriate model of conduct. What is apparent in this scene? What is missing? The issue inherent within the conversation about diversity and professionalism is that the demand to conform to this picture identifies a corollary threat: Deviance from this norm—and from what is perceived as professionalism—has its consequences.

Consider: A black female resident received a negative evaluation that critiqued her for standing while engaging with a patient. It was noted she was “too tall,” which was “intimidating for the patient.” Of note, an equally tall white male medical student in her cohort was also standing in this encounter. Why is the same characteristic commented upon for being intimidating and unprofessional for a black woman but ignored in a white man? What identities are unfairly scrutinized and surveilled, and then rationalized as important to address in order to embody professionalism?

Consider: A male resident was advised to remove his earrings due to considerations of professionalism. The individual in question felt it was an important expression of his gender but submitted to the demand because he felt it would negatively impact his future career trajectory. Why does the type of jewelry signal a physician's capacity to perform as an employee? How do other adornments—tattoos, piercings, a hijab, hair color—undermine perceived authority or competence, and what is the relationship of these stereotypes with status, race, faith, gender, and class?

Consider: In preparation for residency interviews, a black female classmate was told she would need to change her natural hairstyle to something more

“professional,” such as straightened hair, in order to present her “best self” to potential residencies. This was a particular point of difficulty for this classmate, who had only recently made a shift to natural hair. Altering its appearance in this way would require significant time, effort, and financial resources. In addition, the decision felt personal, expressive, and political. In a nation where beauty standards were outfitted upon people who did not look like her, whose hair followed the rules, accepting herself and her features for what they were was an act of self-acceptance and love. It was an arena of self-care, a move towards embracing better mental health. This classmate struggled with the decision—should she surrender herself to demands, and tame her hair into something different and notably not herself? Should she surrender her future to herself as a fair price for any indictments of professionalism that might be flung her way? Consider the energy spent on making and following through this decision, which could have been better spent preparing for interviews. What kind of emotional taxes are placed upon people who look different; what taxes are placed on them in efforts to look less like themselves? How might this scenario look for individuals with disabilities, with traditional clothing, with body art or jewelry? Indeed, how is professionalism defined in this context.

Professional Behavior

Our room of professionals also includes imagined behaviors. What unspoken norms do they follow? How do they react during disagreement? In medical settings, how do they speak about and refer to patients?

Consider: One intern with a physical disability requiring a wheelchair was reprimanded for being absent from Grand Rounds. But the issue was not his dedication, preparedness, or attention. The issue was a consequence of his environment. This student was given limited time to travel from the hospital floors on which he worked to the auditorium where Grand Rounds was held. This time was deemed adequate by others who could walk comfortably through the hospital. He, on the other hand, would arrive late, only to encounter further difficulty maneuvering into a small and already crowded space, impeding his movement and drawing unwanted attention to his chair. Eventually, the physical and emotional labor of negotiating this journey impacted his ability to attend. How does a culture of professionalism inhibit one from asking to have one's need met? How does an unscrutinized demand for punctuality have more deleterious consequences for some people than others, particularly when some disabilities are more or less visible? Though others perceived the problem to

be within the control of this individual, the problem could also have been avoided if the institution itself was more dedicated, prepared, or attentive to creating a more conducive environment where professionalism could have been facilitated by easier access. This student could have presented his cases earlier to allow for extra travel time, and the route to the auditorium could have been examined for accessibility.

Consider: A resident was joking with a bilingual patient in Arabic during rounds. The attending asked that they speak in English in order to ensure other patients feel comfortable, especially since the patient is able to. On another floor, a resident is complimented by a nurse and his attending for sharing stories in French with a patient who had just returned from Paris. What languages are associated more regularly with professionalism, class, and comfort? Whose comfort—patient and provider—takes precedence over others? And what is the source of discomfort or glee when we hear the tones of different languages?

Consider: A male patient made several remarks about a Latina senior resident's "sexy" figure. She felt uncomfortable and diminished, and clearly stated his comments were inappropriate and would not be tolerated again. He responded with a racialized comment about her "spicy attitude." She chose to disengage by leaving the room immediately and was later reprimanded for "unprofessional behavior." How are the "professional" demands to remain pleasant under personal attack much more costly for some individuals? What does it mean to ask someone to calmly and kindly work when their personhood is insulted? In this scenario, the patient inflicted unprofessional behavior upon a provider, and yet the student provider was punished. This scenario can and has been repeated in other iterations. Residents who disagree vocally about the use of derogatory remarks and names when speaking about patients are labeled as oversensitive or angry, and are commanded to meet with leadership about their defensiveness. Women who alert others about instances of sexual harassment often face punitive professional consequences for the disruption, though the violation of professionalism came from another party. What is the emotional burden of working with people who do not respect or defend your personhood, and how does the cumulative impact take a toll?

The preponderance of these stories makes it clear that these are not isolated incidents. Professionalism implies a particular normativity that applies to both appearance and behavior, and these examples illustrate how deviation from this norm results in consequences—especially for individuals who hold identities that sit outside of the "norm" for whom these standards were created. The policing of such standards

thus not only defines an "in group," but also consequently excludes and marginalizes others. While the cases above suggest that this is explicit, we invite the reader to consider the importance of how these issues more often play out implicitly.

Consequences of Implicit Application of a Normative "Professional"

In the fall of 2017, the administration for Yale School of Medicine proposed changes to the evaluation of medical student clerkship performance. One key proposed change was the requirement of a perfect score on the "Professionalism" rubric in order to receive a final evaluation of "Honors." This was followed by a swift response from students, particularly those holding marginalized identities, arguing that this would have inequitable, harmful consequences, however unintended. The argument hinged on more than such stories as those above that indicated explicit reprimands when conformity to professionalism was not met. In fact, this issue fell conveniently on the tail of the release of a study at Yale that highlighted potential consequences outside formal reprimand.

This study, published in August 2017, examined 6000 medical student performance evaluations (aka the "Dean's Letters") from 134 schools applying to 16 different residency programs at Yale to investigate the possibility of gendered or racialized differences in how students were subjectively described. They found that white applicants were more likely to be described using "standout" or "ability" keywords ("best," "exceptional"), while black applicants were more likely to be described as "competent"—and this result remained significant after controlling for board scores. Along lines of gender, they also found that women were more likely to be described in language such as "caring," "compassionate," and "empathetic."¹

Few would argue that these differences were intentional on the part of the evaluators. However, these data support the assertion that implicit (unconscious) biases will inadvertently play a role in trainee evaluation. Thus, when we consider how professionalism is evaluated—a subjective evaluation based in part on particular behaviors and interactions with patients—this study allows us to identify tangible effects of the blanket, uncritical application of a normative "professionalism."

What is the Purpose of Professionalism?

So far, we have introduced a variety of ways in which the enforcement of professionalism causes harm to

individuals, with some affected more than others. This begs the question: What is the purpose of professionalism to begin with?

The notion of professionalism stems from the verb, “to profess,” a public declaration of knowledge and skill. What skill is declared, and how, in particular, can we implement this skill? What corpus of knowledge encircles what our profession professes? What is appropriate to profess? What is barred, mirrored, fed, and threatened?

A nod to the Hippocratic Oath is important, because it elicits a historical grounding to the concept of professionalism. The Oath is not a demand for pupils to be guided by mastery of a particular set of knowledge and skills but rather is a vow to dedicate using one’s knowledge and skills in ethical ways: to do no harm.

The relationship between professionalism and ethics has become so inextricable that they were practically synonymous through much of the historical discussions on this topic. In fact, the critique thrown to medicine has often centered on the fear of losing “professionalism” to the onslaught of corporate and commercial interest (ranging from pharmaceutical influence to for-profit hospitals), and how this would result in the erosion of medical ethics like compassion and altruism.²

With this historical understanding, few would argue that the concept of professionalism itself—as defined by a relationship of occupation with ethics—is inherently problematic. Few would argue with the inherent value of virtues such as compassion and altruism.

However, professions—and therefore any ideology of “professionalism”—are not stagnant Platonic ideals. They are embodied in the real world and therefore will always be reflections of the sociocultural environment in which they operate.

In medicine, we “profess” ourselves throughout our careers. We fix our lips into the phrasing of the Hippocratic Oath, we declare the values of the physician-patient interaction in our embodiment of the

clinical encounter. But the authorities that reside in medicine—the bodies that construct, reify, produce, and define physician professionalism—are vulnerable to the same powers that muscle inequality and marginalization in the world. It is important to recognize how principles of professionalism can be endlessly hostile to individuals that the hospital did not consider when the culture of medicine was being built.

Conclusion: Where Do We Go Next?

What would professionalism look like if it were designed by people who were differently abled, of color, parents, poor? How might it avoid the use of societal standards of professional appearance and behavior (defined by those who do not look or experience the world like them) as a proxy for competence and ethical conduct when caring for patients, which is in fact the historical intent of professionalism?

There is no simple solution to this critique, and we avoid the trap of proposing one. Having expressed the ways in which professionalism is tied to hierarchy and power by nature of being defined by particular individuals at the table, we invite a reimagining of professionalism that genuinely centers on the ethics of the profession: nonmaleficence, beneficence, autonomy, and justice. This requires the very individuals who have been marginalized to take their place at the table in redefining what professionalism is: What it looks like, ways it can be embodied, how it is taught rather than enforced, how it is evaluated rather than policed, and how it can best benefit the entire community, including both patient and provider.

References

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