BSDJ
The British Student Doctor, 2021;5(2):108-110
doi: 10.18573/bsdj.266
Reflections

Queerness and professional identity formation

REFLECTIONS

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No conflicts of interest to declare

Accepted for publication: 02.04.21

Clinical medical education should help us transform from someone with knowledge about medicine to a practicing doctor. Medical school should help us navigate this transformation of identity, merging it with our other identities in a consonant way. But is this process different for medical students who identify as LGBTQ+? Can an understanding of queerness be helpful? We reflected on our experiences at medical school thus far through the lens of professional identity formation.

The current dominant view defines professionalism as a set of behaviours; a role that is performed with outcomes that can be assessed. (1) An example of this framework would be the General Medical Council's Outcomes for Graduates, a document labelling the requirements for newly qualified doctors in the UK. (2) A second framework of professionalism is professional identity formation (PIF), where students are socialised into a community of doctors. (3) This view suggests clinical education to be a process of enculturation; whereby students should gradually acquire the accepted ideals of clinicians, over time thinking, acting, and feeling like professionals. (1) We find PIF to be a more helpful and accurate description of how we are shaped into clinicians.

The use of the word queer in this essay is purposeful. We view the interaction of sexual orientation and queerness in the same way we view the difference between professionalism as behaviours and professional identity. The term 'sexual orientation' was first used in the 1970s, then implying a definitive quality about someone and the relation of gender to sexual object choice. (4) Queerness more closely resembles the nonsexual meanings of the word 'orientation' – encompassing feelings, beliefs, and attitudes. Beyond a set of behaviours, queer identity brings with it practices, aspirations, and social locations. (4) We want to use the term 'queerness' to counter the model of sexual orientation as risk behaviours, which we often see in medical education. We feel that this can lead to harmful learning through the hidden curriculum; a term used to describe implicit messages we receive about norms and values,

which can be inferred from the behaviour of individual role models, such as lecturers and consultants, or from processes and structures. (5) Alongside this, lies the null curriculum, the conspicuously untaught content, to be interpreted as unimportant. (5) We recall that mentions of LGBTQ+ people in an educational context have nearly always been as a risk factor for disease or as a diagnostic "clue" in problem-based learning sessions. From this, students can learn that their only interactions with LGBTQ+ people will be as a consequence of their risk behaviours. Moreover, the absence of varied queer representation suggests that future professional encounters with LGBTQ+ people not focusing on risk behaviours will be negligible and, ultimately, unimportant.

Of course, the hidden curriculum communicates more surrounding identity: not only the identity of others but of ours as soon-to-be doctors. The standard for understanding patients' identities in our medical education is cultural competence. This aims to produce practitioners who consider and value the worldviews of themselves and others. Cultural competence education has been criticised for treating the doctor as an unproblematic and neutral centre (or 'null point') in relation to which the identities of "others" can be arranged. (6) If we accept this criticism, students could logically infer that practitioners are separate from the "others". This defines not just who our "normal" patients are, but who a "normal" doctor is – white, Western, heterosexual, cisgender, middle-aged, and a first-language English speaker. This implicitly communicates that we are different from the professionals who define the community. Furthermore, the enacted teaching of cultural competence disproportionately focusses on cross-cultural communication – this being the measurable, desired endpoint. The implications of accepting doctors as a 'null point' and drawing focus on communication skills inadvertently contradicts the formal aims of cultural competence by neglecting to provide us, as students, with suitable tools for evaluating our own worldviews.

The enculturation process, within the PIF framework, involves internalisation of the core values and 'worldview' of the profession. To do that successfully, we must first evaluate our own worldviews – a challenge in itself – and determine whether the perceived values of the profession are congruent with our own. Costello, a leading sociologist on professional identity, suggests that integrating professional and personal identities can be harder for some due to identity dissonance – the incongruence between one's own multiple identities. Further, students with identity dissonance could be more likely to develop coping mechanisms such as "role playing" in professional situations. (7) Adapting to professional appearance could be one such example. Anna feels they perform traditional interpretations of femininity (such as wearing dresses and make-up) much more in a ward environment than they do in their personal life to balance having ultra-short hair. Whilst on placement, Sam dresses more masculine and wears more muted colours. Anna is concerned about the reception from seniors, whereas Sam feels they need to present within the traditional gender expression of "men" to meet what patients would expect from a doctor.

Ultimately, incongruence of identities can cause such discomfort that an individual no longer wills to become a member of their prospective professional community. During their time at medical school, the simultaneous but divergent growth of Sam's personal and professional identities has led to questioning of both. On several occasions, this has motivated thoughts to drop out of medical school, thereby resolving the tension caused by the emergent (and optional) professional identity. Anna has also experienced difficulties in the process of socialisation into the future profession. Below is a story from their colorectal placement.

I was observing a colorectal list and waiting for the next patient, coming in for exploration of rectum under anaesthesia. While the patient was moved and positioned onto the table, the consultant gestured me and the other medical students towards him. "He claims he has pain due to haemorrhoids, but I don't buy that", the consultant said to us. "He's gay and practises anal sex." He appeared pleased when the other two medical students started giggling. I felt uncomfortable and confused. This was treated as an acceptable 'joke' by the clinicians and students present but did not fall within my definition of professional behaviour.

To us, forming a professional identity feels like a "chicken and egg" scenario. Do we copy behaviour we see examples of until we form an identity as a 'professional', or do we have an idea of the kind of doctors we want to become first, and therefore behave in a way to fulfil our standards? According to PIF, having positive role models and exposure to doctors with qualities that resemble our own is crucial to our professional development (1). There are queer doctors out there, but there is also immense pressure to fit within the frame of what a 'professional' looks, dresses or acts like. We feel the prescriptive nature of both frameworks discussed may contribute to our experience of this pressure. Yet importantly, we also self-categorise who we are not, (8) and construct identities by noting differences. We feel like Anna's experience illustrates how there will always be professionals whose values appear to contradict our own. By seeing few role models resembling ourselves in the clinical world, maybe we need to lean more into thinking about what kind of doctors we want to be, rather than mirroring the behaviour of those already out there.

To make this enculturation process easier for queer medical students, how do we change a culture? Ideally, values congruent with our own would be communicated by the wider institutions we are a part of. Medical schools should be intentional about widening the view of what a doctor is. In the case of queer medical students, they should incorporate better LGBTQ+ content in their curricula – moving away from the harmful behaviourist framework. Medical schools should stop relying on advocacy from student groups or individual faculty members with a stakeholder interest, but instead hire education consultants with experience of these issues. Seniors should be held accountable by their peers, rather than a culture of

fear of challenging explicit and implicit trans- and homophobia. However, we do not see this shifting soon. Meanwhile, maybe small acts of resistance, or secondary adjustments, (9) can be a safe way to chip away at existing culture. We can assess our personal levels of comfort and present more visibly queer in clinical environments. We can make it a point to ask patients about their pronouns at the start of our interactions. e can practice respectfully challenging views of peers, clinicians and patients.

Although queer medical students might struggle more with some aspects of PIF, it still has its merits. The PIF framework seems more able to consider multiple, complex identities through focus on the integration of individuals and communities. Queerness can entail a better understanding of identity as a concept, as queer people must understand themselves in relation to heteronormativity. Some of this thinking may be transferrable to thinking about our professional identities. Hopefully in the future, with a wider view of who a doctor is, more students can see themselves as part of the professional community

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Journal DOI
10.18573/issn.2514-3174

Issue DOI
10.18573/bsdj.v5i2

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