

Thank You, Y-Dang

I write as a community-based pediatrician. The thoughts expressed in this essay are based on learnings through years listening, watching, and being present during patient encounters, then reflecting back on the educational process. It was in my role as a community pediatrician that I met Y-Dang through a chance clinical encounter that reshaped my understanding of the many meanings of being “professional.”

I entered medicine as a “mature” student in my thirties, single-parenting two young kids, decorated with a lifetime of tattoos after having spent a few years as a teacher. The invisible scars of a traumatic childhood and Latin heritage contributed to my otherness and were (thankfully?) hidden through the entrance process. But they appeared to become immediately visible to others, a visibility likely stemming from my questioning the systems and values we were taught.

There followed an eight-year attempt by both medical education and residency training to mould me into the image of a “professional” doctor by systematically quieting my voice through persistent negative reviews about *who I was*; there was never a question about my medical competence, and I had some near-perfect scores in content exams. Near the end of my last year of medical school, however, the Faculty of Medicine threatened expulsion and brought me up for review by the Dean of Equity and Professionalism. The outcome was that, in order not to be removed from medical school in the final months of a four-year program, I had not only to attend all classes until the end of my degree, but to comment in each class—and these comments could not offend anyone. Comments considered offensive included bringing up any critique of racially profiling patients, questioning the points of view of “references” in required readings, and highlighting systemic issues of oppression within the medical curriculum. Examples included when I questioned whether teaching that an “Aboriginal” identity was a risk factor for liver disease may overlook the impact of

intergenerational trauma, racism toward Indigenous patients, or the over-representation of Indigenous families in cases involving child protection; and when I questioned the history and meaning, including the potential violence, of the kinds of “evidence” lauded in evidence-based medicine. At the same time, others’ offensive comments were carefully explained to me by my peers: “He was joking when he said he could not be a gynecologist as he didn’t want to turn gay.”

The moulding continued through residency where, as a pediatric resident (and the only single parent), I continued to receive negative feedback about *who-I-was*; again, my medical competency was never in question. While in one of my first rotations of pediatric training, a senior resident (a learner in their final years of training) tried to fail me but could not come up with a valid reason. Their sharing their dislike of me with staff and other senior residents, housed under the guise of “concerns about my abilities,” had profound impacts on the remaining four years of my training. My questions became signs of a “lack of confidence,” and any confidence I had shattered under unrelenting personal critique. I needed to be composed when I was given increasingly common feedback: “I was surprised when you were not so difficult to work with!” I tried Botox as “my eyebrows moved too much,” and I tried to stop smiling so much, as this was not professional, all while rushing home to try and be present for my growing children. I graduated from my residency in October 2017, and from then on was finally able to call myself Dr. Richardson, a community-based pediatrician. Whatever emotion or response this title elicits in the reader, it hides the process trauma it has taken for me to get here.

After finishing my training as a pediatrician, I worked as a locum (covering for another pediatrician), and it was there I met Kai, held by Y-Dang with her partner beside her: the unit trio. They were newly arrived from Hong Kong and Kai was not growing well. Through initial uncertainty, he grew and thrived, and our medical appointments transitioned from mostly talking about Kai into more time talking with Y-Dang. Medical visits turned into opportunities to have conversations around shared interests and values. It was through these conversations that *who-I-was* started to matter as much as *what-I-knew*, and Y-Dang began the process of reconstructing the pieces left behind in my medical education and training. Y-Dang gifted me with her curiosity and allowed space for dialogue. I had to work against my training to

overcome the initial hesitation I experienced in sharing so much of the personal; where was the boundary between personal and professional?

Y-Dang introduced me to many concepts, such as ableism and critical disability studies—topics that were not part of the lexicon gained through medical education, but that align with both *who-I-am* and *what-I-know*. She gave subject headings to the questions that had resulted in my being disciplined, and my questions gained substance. Y-Dang's work is at times described as “uncomfortable” because she trespasses traditional academic writings through narrative and personal stories. She lays bare her own process trauma, experienced when publishing *Refugee Lifeworlds*, in her second book, *Landbridge*. She shares that her work was considered not “academic enough,” the subject matter “too minor for a scholarly work,” and that she “could not claim to be an expert on the subject matter” (19). Perhaps she too would have been an unprofessional medical learner.

In *Refugee Lifeworlds*, aphasia (the medical term given to the inability to use words to communicate) provides the basis of a chapter that highlights hierarchies of power. Here, Y-Dang shows how using a term such as *aphasia* pathologizes trauma and sterilizes refugee experiences under a generic clinical diagnosis. She shares the story of the kapok tree, and how *dam-doeum-kor*, “planting a kapok tree,” meant keeping safe through the Cambodian genocide. The Khmer word *kor* means both “kapok” and “mute.” Therefore, keeping quiet kept you safe. Aphasia removes nuance and context, allowing for separation in clinical encounters with patients to the now, reducing the how into a single, distant, and “objective” term.

This chapter resonated with me as someone who works mostly with children who do not communicate with words. “Non-verbal” is used by colleagues in a similarly meaningless way to pathologize a deficit, reducing communication to speech that is heard, and centring verbiage as the preferred way of being. My relationship with Y-Dang shifted a little more. I started reflecting on my education but now had the beginnings of language to describe the discomfort I felt about what I learned in medical education. Y-Dang saw me as a researcher and gifted me this as a more nuanced, contextual, and alternative label to “unprofessional”; she invited me to present at UBC and then to apply to become a Wall Scholar there—a position I had not heard of nor would ever have considered applying for.

With her encouragement, I did apply and was accepted, and I learned that some scholars consider my otherness a welcome trait. A year spent in dialogue with a few scholars interested in complexity continued the rebuilding process begun by Y-Dang. I now write unapologetically and question the definition of *professionalism* in medicine, the vague term that almost prevented me from being open to dialogue with Y-Dang, a patient's parent.

I was first introduced to what professionalism looked like in medicine in my first days of medical school. My children were five and seven at that point, and I didn't have enough time after the bus came to pick them up for school to arrive on time for my early-morning small group sessions. Although I explained my situation, this resulted in a P- ("Pass minus") as my final grade for Professionalism. I learned that professionalism in medical school meant being like other medical students: having a second parent in the home, or enough money to afford a nanny, or simply not having children. It is my belief that the emphasis on professionalism in medical education works in opposition to meaningful movement toward anti-oppression and anti-racism; this is one of the hidden curriculums of medical training. Professionalism is weaponized in medical education to get rid of otherness and to encourage homogeneity.

What makes a "good doctor" is an incredibly complex interplay between medical expertise and how this expertise is applied. CanMEDS, a set of professional standards used in medical schools across Canada, attempts to define a medical expert through a role-based framework "that identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve" ("CanMEDS Framework"). One of the seven roles is the "Professional": "As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health" ("Professional Role"). But who sets these standards, and are we protecting the public or holding onto power?

Professionalism through medical education becomes an identity, not a competency, and guides both *who-I-am*—what you wear, what you look like, how you speak, your facial expressions—and *what-I-know*. We are taught the importance of maintaining professional distance from our

patients—and this distance is detailed in professional standards such as those outlined under “Non-Sexual Boundary Violations,” as set out by the College of Physicians and Surgeons of British Columbia, which holds our licence to practise medicine. The relationship between a physician and patient is one of vulnerability for the patient and power for the physician. However, I wonder if professionalism maintains and enforces this power dynamic: to be professional, you must be distant, rational, and objective (and cover up your tattoos). There are absolute boundaries in a doctor-patient relationship, but the boundaries that cannot, and should never, be crossed are fundamental to the ethics and values of being human. I still feel a great degree of discomfort writing this essay as the ideas shared are both subjective and affective, traits almost in opposition to the ideal of professionalism we are taught.

Y-Dang gifted me with seeing myself as enough, not as unprofessional, which allowed me to be both myself and a doctor as she disciplined notions of social justice in her writings and in our conversations. Challenging the status quo ought to be encouraged in medical learners: learners bring the new ideas and ways of thinking that are needed to shift the practice of medicine forward and outward. Diversity in thinking, in dress, in ways of talking and looking reflect the diversity of our patients and allow for relational practice. Being in practice *with* patients, as opposed to distant from, allows space for true dialogue, where learning occurs in both directions and this makes me a better physician.

She held my hand while we talked, her eyes closed, her partner behind her. One last gift given so freely, like all the others. I suppose some could call me unprofessional.

Works Cited

- “The CanMEDS Framework.” *Royal College of Physicians and Surgeons of Canada*, 2015, <https://royalcollege.ca/en/standards-and-accreditation/canmeds.html>.
- “Professional Role.” *Royal College of Physicians and Surgeons of Canada*, 2015, <https://royalcollege.ca/en/standards-and-accreditation/canmeds/professional-role.html>.

| *Anamaria Richardson is a community-based pediatrician that encounters life as research.*