Humanism or Professionalism? The White Coat Ceremony and Medical Education

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Abstract

In this article, the author challenges the widely held assumption that humanism and professionalism are necessarily complementary themes in medical education. He argues that humanism and professionalism are two very different value systems with different rationales, different goals, and different agendas. Whereas humanism is a universal, egalitarian ideology, professionalism represents the parochial, culturally determined practices of a particular professional group that may or may not conform to lay expectations.

Distinguishing professionalism from humanism is crucial to understanding the divergent attitudes of providers and lay persons with regard to health care delivery and physician behavior. Moreover, it highlights the tension that medical students experience as they are tacitly asked to leave behind their lay, humanistic values and embrace a new professional identity, a transition that the common blurring of humanism and professionalism fails to recognize. In this context, the Arnold P. Gold Foundation's widely acclaimed White Coat Ceremony for entering medical students may actually be inhibiting, rather than encouraging, the genuine growth of humanism in medicine.

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> Even the graduate student should not lose sight of general cultivation and fall into stark professionalism.
>
> —B.A. Hinsdale, Studies in Education: Science, Art, History. Chicago, Ill: Werner School Book Co., 1896.

The purpose of this article is to highlight some of the tensions inherent in the messages that the medical community sends to its students, not only through the White Coat Ceremony but also throughout their training experiences. Specifically, the medical community regularly lectures its students about the dual values of humanism and professionalism without regard for either the distinctions between them or the tensions that can arise between them, both in training and in practice. Worse, there is a growing trend to assume that professionalism itself fully encompasses humanistic values and that professionalism alone can therefore represent the entire aspiration for virtue in medicine. I argue that this tendency towards professional reductionism impoverishes, rather than enriches, our moral base and could ultimately leave medicine bereft of a true humanistic moral compass.

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Although this is concerning for medical practice generally, I believe it is most poignant, and perhaps most harmful, in the context of medical education, as medical students first encounter the profession of medicine and seek to develop their own identities as physicians. In promoting the dual values of "humanism and professionalism,"[1] or actually enveloping the former within the latter, as in "humanism is . . . central to professionalism,"[2] the medical community confuses more than it clarifies, and it hampers, rather than encourages, deep moral development in medical students. I will examine these issues as they pertain to the White Coat Ceremony, primarily because of its visible role as the harbinger of a new wave of professionalism education and because it serves as the actual initiation point for many medical schools.[3–4] However, the issues that the White Coat Ceremony raises for medical students do not end with it, but persist throughout medical education and beyond.[5] Ultimately, the more clarity we can present to our students about the multiple, and sometimes competing, dimensions of medical practice, the better we will empower these fledgling physicians to balance them with grace and with insight.

Humanism Versus Professionalism

"Humanism and professionalism," it seems, has become somewhat of a catchphrase for medical education. Compelled by a sense of dissatisfaction with the training for the nonmedical aspects of physician practice, medical educators have increasingly sought both to teach and to measure a set of values and behaviors that are broadly labeled as "humanism and professionalism." The highly respected Dr. Arnold P. Gold has described how he felt that "students were undervaluing humanism and professionalism,"[6] motivating him and his wife, Dr. Sandra Gold, to launch the pioneering Gold Foundation, the sponsoring organization for the White Coat Ceremony.[7] Similarly, the Gold Foundation's most recent initiative, The Gold Humanism Honor Society, has been "organized to elevate the values of humanism and professionalism within the field of medicine and its constituent institutions."[7] Describing the White Coat Ceremony, a recent review of teaching professionalism explains it as a process by which students "learn the meaning of responsibility that comes with wearing the white coat, the expectations for humanism and professionalism."[1] Another commentary on the White Coat Ceremony reflects this language: "the white coat emerges from the ritual as a symbol of professionalism and humanism, and remains a tacit reminder throughout medical school."[8] Finally, I note that my own medical education included a curricular module termed "Humanism and Professionalism,"[9]

overseen by the associate dean for professionalism and humanism.

Some have gone even further, not just pairing humanism and professionalism but subsuming humanism within professionalism. Thus, "Project Professionalism," a publication of the American Board of Internal Medicine, states that "humanism is . . . central to professionalism."[2] This language is almost exactly duplicated by Dr. Gold, who has written, "Humanism is the central aspect of professionalism."[10] From this perspective, discussion of "humanism and professionalism" is almost redundant because medical professionalism has seemingly embraced the spirit and the values of humanism without reservation or exception.

More recently, Cohen[11] has argued for independent definitions of humanism and professionalism and the indispensability of each for medical education. Still, for Cohen, too, humanism and professionalism are fully complementary, with humanism providing "the passion that animates authentic professionalism." Together, they represent two halves of a unified, coherent vision for physician virtue, devoid of any internal tensions or contradictions.

The tendency to combine humanism and professionalism probably stems from a considerable overlap in their constituent elements. Empathy, compassion, respect, and integrity, for instance, could easily be described as components of both humanism and professionalism. However, I question both the conceptual validity as well as the ultimate wisdom of conflating these two terms. Humanism and professionalism, in my understanding, identify two very different ethos of physician practice and emerge from divergent visions for the physician–patient relationship. Although they may often make overlapping and complementary demands of a physician, they can also split, run counter to each other, and collide. Furthermore, blurring the distinctions between the two undermines both, as students and physicians alike are drawn towards the homogenized commonalities between them and are led away from critical reflection on the subtleties of either.

It is not clear who first stitched together the terms "medicine" and "humanism," nor exactly what was intended at the time. For my purposes, I will adopt a fairly broad understanding of humanism, as articulated by one of my own mentors: the accordance of deep respect to humans individually, and to humanity collectively, and concern for their general welfare and flourishing.[12] Although it is not at all difficult to imagine how this tradition intersects with clinical medicine, it is also crucial to understand exactly what it lends to the profession of healing. The hallmarks of humanism are its universality, its egalitarianism, and its scope. Its concerns, on the one hand, and obligations, on the other, apply to all humans equally; its training ground, for the most part, is experience—as a human and with humanity; and its ultimate vision is for human welfare, as broadly conceived as possible. It requires neither professional expertise nor special knowledge, only reflective and thoughtful human beings who are ready to engage one another across multiple dimensions. Furthermore, it is in no way bounded by clinical medicine but transcends it. Rather than embody the totality of humanism, the sensitive physician at most humbly participates in its venture, making his or her small contribution to the grander project of human well-being.

Professionalism, in contrast, is a socially constructed, local phenomenon. It is rooted in a sociological understanding of a "profession," for which I rely on the late Eliot Freidson's[13] classic definition in his landmark *Profession of Medicine*: a group of specialized workers whose expert knowledge earns them the right to function independently as a semiautonomous mini-society. The strength of a profession as a social unit lies in its members' assertion of a distinct and consolidated collective identity, whether through participation in professional organizations; the nurturing of a rich, internal professional culture; or censure of those who deviate from the profession's standards of conduct. Professionalism raises expectations for professional behavior to the level of ideology, encouraging all members to embrace the traditions of the profession and to be as "professional" as they can.

But what, exactly, does it mean to be professional? Though professional traditions do contain moral commitments, they also include a diverse range of other cultural components. Empathy, respect, and compassion, for instance, are certainly part of medicine's self-image, but so are certain standards of the appropriate dress, demeanor, language, and habits of a physician; a level of comfort in trespassing usual social taboos of exposing and touching strangers; a readiness to blend patient care with student mentoring in clinical contexts; a tacit understanding of the limits of physician responsibility; and a vision of medicine as an essentially scientific field. None of these elements by themselves are outright objectionable, but several of them are unquestionably value laden and could be subject to discussion, yet they are usually justified by little more than the traditions of medicine themselves. An ideology of professionalism simply promotes all of them indiscriminately without offering any basis for introspection.

Several other features distinguish professionalism as a guide for physician behavior from humanism (see Table 1 for a summary). While humanism appeals to universal values, professionalism is rooted in the local traditions of a group whose self-identity lies primarily in its distinction from the surrounding lay community. Anyone with a good head and sharpened sensitivities may comment

Table 1
A Summary of the Differences Between Humanism and Professionalism

Characteristic	Humanism	Professionalism
Types of problems	Universal	Local
Sources of learning	Human experience	Socialization into profession
Motivation	Human welfare	Strengthening of professional identity
Primary duty	To other humans; to society	To the professional group
Cognitive basis	"Postconventional thinking": Judging behavior through deliberation about universal values	"Conventional thinking": Judging behavior by comparison with the accepted social norms of a specific group

on humanism, whereas the normative understanding of professionalism belongs to the professional group, which manages how much of a voice outsiders are granted.[13] The content of professionalism, too, is narrower than that of humanism because the professional group defines what the content and issues for professionalism will be. Values such as courage, loyalty, patience, and humility, for instance, receive little attention in discussions of medical professionalism, whereas their relevance to everyday human interactions makes them central to humanism.

Motivation is also a dividing point for humanism and professionalism. Humanism emanates from a primary duty towards humanity. Professionalism, on the other hand, relates only indirectly to society. Enhancement of the profession's service to society might be a result, but professionalism itself is aimed primarily towards protecting the autonomy and integrity of the profession for its own sake.[14] Medicine, in fact, is a case in point. Speculation about the reasons for the current resurgence in medical professionalism abounds, but one undeniable component is the medical profession's need to reenergize itself as a strong and self-governing independent entity at a time of public doubt and encroachment.[1,15]

Finally, and perhaps most critically, humanism and professionalism differ in the way that individuals discover, negotiate, integrate, and apply them. Humanism, at its heart, is a philosophy. Although social processes may contribute to humanistic moral development, the doctrine is an essentially cognitive one and, therefore, always subject to rational discourse. As a way of life for the individual, humanism is fashioned out of reflective experience, a dialectical process of calibrating theory to practice and vice versa, ever further refining both character and behavior. The professions, and medical professionalism, by contrast, are social phenomena. The primary mode of initiation is not through rational learning but, rather, through an intense and well-studied socialization process through which newcomers absorb the social traditions of the group.[16–19]

To borrow terms from the field of moral psychology, professionalism typifies "conventional thinking," whereas humanism is an example of "postconventional thinking."[20] Conventional thinking judges behavior through the narrow lens of social convention. Postconventional thinking, on the other hand, seeks to transcend mere accepted practice and construct fair, universal guidelines for human interaction. Whereas conventional thinking flows from an undue fascination with established social roles and norms, postconventional thinking thrives best when we break out of sectarian outlook and social rank, indulging instead in our common human identity. Postconventional thinking is a deliberative process through which we consider multiple perspectives and identify common core values. Conventional thinking, on the other hand, relies completely on comparison with an isolated group's conventions and offers no language through which to actually analyze the judgments it passes.

What follows is that humanism and professionalism for the physician are fundamentally different ways of operating. Regarding humanism, lessons learned from the medical context may be instructive, but humanism actually flows most naturally from a lay, rather than a professional, identity. Professionalism, in contrast, both represents and feeds a preoccupation with professional identity and contributes to isolating the physician from the lay public.

The limits of professionalism also become apparent. As with all forms of conventional thinking, professionalism cannot distinguish between different types of transgressions on a rational basis. In contrast to humanism, which is logically constructed out of foundational principles and can therefore develop a sophisticated hierarchy of moral responsibilities, professionalism confronts a static field of arbitrary conventions without any analytical tool for assigning moral weights. Acting unprofessionally means little more than deviating from the conventions of medicine. By itself, professionalism cannot explain why lying to a patient, for instance, is worse than wearing a T-shirt to work, other than to grade different professional traditions as more or less central to medicine. Such an undertaking, however, would be a sociological inquiry, not a philosophical one. No wonder that medical professionalism has fascinated sociologists,[21–23] whereas some philosophically inclined clinicians have regarded it as conceptually thin.[24–25] Humanism, on the other hand, can offer a coherent argument for why deception more gravely disrespects a patient's essential humanity than does dressing down in the clinic.

None of this means that medical professionalism is self-serving, disingenuous, farcical, or even dispensable. To the contrary, medical professionalism is for the most part aligned with noble, humanistic ends, and the force of its total vector has generally pointed in the same direction as society's interests. Moreover, even Eliot Freidson,[14] famous for his critique of the medical profession, defended the absolute necessity of an autonomous profession with its own professional ethic. What does mark professionalism, however, is its socially constructed nature and, therefore, its essential arbitrariness; its heterogeneous tangle of overlapping, intersecting, and contradictory goals and interests (e.g., the conflict between improving access to care[26] and preserving a long tradition of high compensation for physicians); and its conventional, rather than deliberated, character. Just realizing how differently various medical circles have interpreted professionalism over time ought to chasten those who currently swear by it. If professionalism in the 21st century emphasizes the art of medicine over its scientific component, for instance, the exact opposite was true at the beginning of the 20th century, when professionalism in medicine meant emotional distance and scientific stoicism above all else.[27]

Even today, after so many organizations have taken steps to articulate the expectations of professionalism, gaps, doubts, and inconsistencies persist. For example, authors have noted how supposed professionalism, both in theory and in practice, has been surprisingly tolerant of an increasingly aggressive commercialism among physicians[23] and of ever-closer financial ties to the pharmaceutical industry.[28] If the professional societies responsible for the professionalism agenda are themselves complicit,[29] from whence can come a critique? And, if lay humanism has indeed become central to medical professionalism, how do we explain the disparity between public outrage and

professional smugness with regard to these practices?

At The "Rough Edge" of Medical Education

To document the tension between humanism and professionalism, one need only observe third-year medical clerks as they shift from passive absorbers of medical knowledge to active participants in the health care system. If this transition is stressful, one of the primary reasons is because these clerks must suddenly leave behind a purely lay identity and internalize an entirely different,[17] unreflective culture,[30] including a radically different cultural understanding of humanism. Here, deep ethnography gets replaced by curt social histories; human relationships must adapt to a tight and inflexible hierarchy; and humanism is rationed out in ways that don't interfere with the health care engine. Whereas students' college educations likely championed respect for persons and personal integrity above all else, their early clinical training now instructs them to enter, disturb, wake, undress, and examine at will in an environment that hardly offers the patient a chance to protest. Even their early, modest forays into the clinical setting as first- and second-year students, whether to observe or to shyly practice interviewing and examination skills, barely prepare the clerks for this new reality: "Often in the hospital setting I feel I intrude into people's lives, take what I want, and move on."[31] Whether this mode of practice is justifiable or not for the sake of health care delivery is not the question. Even if we assume, somewhat generously, that it is unavoidable, this doesn't change the fact that these behaviors inevitably betray and, quite possibly, erode[32] the lay sensitivities of medical students to a degree that the medical profession rarely acknowledges.

We can learn much about the rough edge of humanism and professionalism education from examining medical students' self-reported internal tensions and conflicts. Several studies, both qualitative and quantitative in nature, have documented the ethical lapses that medical students both observe and participate in during medical school, as well as a trend towards lower standards as medical education progresses.[31,33–44] In fact, these data sets have been instrumental in prodding the medical community to invest more heavily in humanism and professionalism education at the undergraduate level.

However, what is missing from many of these analyses is the recognition that value judgments such as "unethical" and "unprofessional" have a sociological component to them. Charles Bosk[45–46] has emphasized a similar point with regard to medical error, arguing that the very definition of "error" is a "negotiated concept," subject to interpretation and influenced by one's role in the health care system. The same holds true for judgments of conduct. What a patient considers rude might seem acceptable to a physician (e.g., immediate total-body exposure of trauma patients in the emergency department), and what an ethics panel flags as troubling might seem unavoidable to the health care team. Straddling the great divide, of course, is the medical student, who lives on the ever-so-thin boundary between lay and professional. Depending on the day, or the mood of their superiors, medical students may either be granted entry into the hospital's work group or be treated as outsiders. Similarly, students themselves study their environment from both sides of the nurses' station, viewing it alternatively as insiders or through the eyes of the lay community from which they are still emerging.[40] What they call inappropriate may reflect the consensus of the professional community into which they are assimilating, or it may deviate sharply from the mindsets of their superiors and find more in common with a lay perspective.

The cases in which medical students voice a lay perspective, in particular, can provide a unique lens through which to view the struggles between lay and professional, between humanism and professionalism, as they unfold in the hearts and minds of tomorrow's doctors. Although popular wisdom holds that these two value systems should peacefully coexist in the soul of a medical student, the data, I believe, suggest that this is not always the case. Of the total pool of ethical violations described in the above-mentioned studies, at least some of the judgments seem to be student specific, meaning that the professionals involved, whether residents or attendings, did not apparently recognize that anything at all had been compromised. To be sure, not all of the physician behavior and attitudes described by the students conform to the various codes of professionalism that are bandied about today. However, if we take the social nature of professionalism seriously, then the norms of actual practice in the professional context should mean far more for our understanding of professionalism than any position statement. Although the cases I draw from may not be exemplary, none are fringe, either, and that says the most of all.

Students' reported dismay about the seemingly normal functioning of the health care system around them falls along several different themes. By far, the most common is student discomfort with the power and authority of the health care team over its ward. Whereas the students imagine a more even relationship between practitioner and client, the hospital setting in practice robs patients of much of their control over their illnesses, right down to their very diagnoses. For example, several students quoted in these studies are taken aback by how carefully the health care team regulates the sharing of diagnostic information:

> Pathology report came back for a patient with colon CA. I was instructed not to tell him—wait for the attending to tell him. The attending was on vacation for the week.[34]

> When I learned that the biopsy of a lung nodule showed an undifferentiated cancer, I was very upset but I wanted to be there when [the patient] was told. When I asked my resident *who* would inform the patient of the biopsy results, he instructed me that no one on our team was to say anything. Instead, the oncologists would tell him. . . . For the next two days, the patient repeatedly asked me if I knew the results, and with many misgivings I told him "no." When he finally learned, he was very angry that I had kept the truth from him—and I couldn't blame him.[33]

> On my medical rotation, there was a patient on the floor who had lung cancer but [the physicians] weren't sure [of the type]. Nobody would tell the patient that he had cancer. . . . It was very clear that the patient could have been told he had cancer but they just didn't know exactly what type it was and they didn't want to get into specifics until they knew that every test had been done. This patient was probably in the hospital close to a week and a half, and, every time I would go in the room, he would keep saying to me, "I

> don't have cancer do I?" And I was not at liberty to even tell him anything because the staff and the respirologist wouldn't tell him.[39]

In the modern health care system, medical results do not belong to the patient. Rather, they rest with the attending physician, who controls when, where, and how to share them with a patient. The students' superiors take this ownership for granted, even in extenuating circumstances. The students, in contrast, express deep misgivings about this form of authority, as they find themselves uncomfortably situated right at the gap between physicians' medical omniscience and patients' frustrating blindness.

More directly demonstrative of the tug-of-war between humanism and professionalism is students' surprise with the boundaries of medicine. Whether in taking a history, presenting a case, developing a problem list, or coordinating management, the students are led to gloss over aspects that are deemed nonmedical (itself a value judgment) in favor of the quintessentially medical. Whereas the students approach the clinical context with an expansive, humanistic conception of health and flourishing that includes social concerns, they sometimes find that their superiors exclude primarily social problems from the medical realm and focus only on organic disease:

> A 72-year-old woman had been readmitted for another exacerbation of her chronic obstructive pulmonary disease, precipitated by her failure to take her medicine. Over the ensuing week I got to know her, and she confided in me that she was homeless but was "looking for a good place." She also made me promise that I would not tell this to anyone, since she did not want social work or psychiatry involved in her case. She responded well to treatment and as she approached discharge, my attending asked her where she would be going. She replied that she had an apartment lined up. While I felt that I couldn't violate her confidentiality, I did hint that she might not have any place to go. My intern replied that she was competent, had said that she had secured an apartment, and that he wanted her "off his service."[33]

The student, apparently, sees great irony in narrowly focusing on an acute respiratory problem while ignoring the larger threats to health and well-being in this chronically ill patient. Moreover, discharge under these conditions almost guarantees relapse, making the whole effort self-defeating. The intern, however, is uninterested. Whether out of cynicism, resignation, or both, he has learned to define his own professional role just that narrowly. The patient's next admission will belong to someone else.

Of all of the studies, Parsons et al's[40] "Between two worlds: Medical student perceptions of humor and slang in the hospital setting" is most insightful in noting the unique sociological position of medical students. According to Parsons et al, students may be alternatively "outsiders" or "insiders" to the medical culture, capable of identifying with either the patients' or the physicians' perspectives. Early on, students express shock at the slang and humor in the hospital, observing from the sidelines and questioning the appropriateness of the humor:

> [The residents were] talking about older patients as toads and frogs and gomes [a shortened form of GOMER]. I had never heard patients talked about in that way. And just going from the classroom to the clinics with all these ideals of what doctors were supposed to be like. . . . It was 20 [physicians] sitting at breakfast together like a big football team and talking about patients in a way that was very disappointing.

Over time, however, the students learn to identify with their superiors, growing more accepting of the humor and even participating. The same student who described initial disappointment then explains the shift in attitudes that came with finishing a subinternship:

> I was so shocked at the way doctors talked about people in the beginning. But having just finished a month of being that tired and sleep deprived, and being up all night for really stupid things, I can see where the frustration comes from. I still don't think it's right, but I can understand it a little. Now it's no longer inconceivable to me why people talk that way about patients and families.

Yet again, we encounter a form of behavior that by no means conforms to the party line on professionalism, yet is, for the students, part and parcel of belonging to the medical profession. Moreover, whereas at first the students align themselves with the ridiculed patients, they learn through their training to think and act more and more like the professionals they report to.

It would be easy to dismiss the behavior in all these cases as both nonhumanistic and unprofessional. Rather than descend into a semantic squabble, I will highlight one simple point: *that's not how the students saw it*. For them, this was professional medicine at its most authentic. For the same reason, I have glossed over any distinction between resident and attending behavior in this context because both, I believe, were representative of professional norms for the medical students. From their perspective, their collective, naïve conscience was hitting up against the conventions of professional practice, and, in many cases, it succumbed. As the data suggest, the students evolve over time, willing, for instance, to speak about patients in ways that they themselves used to find disturbing.[34,38,40]

How, exactly, should we describe this transition? Specifically, is this indeed a phenomenon of losing values, or would we better describe it as a gaining of a new set of professional values? More broadly, when a medical student learns to ask an embarrassing question of a patient on morning rounds without blushing, or to mold a complex story into a slick but anonymous presentation, or to use ward humor as a pressure valve, is this a loss, a gain, or both? And the answer is crucial because the storyline of ethical erosion is central to the current wave of professionalism in medical education. Educating for professionalism is a solution to a stated problem, a way to preserve the ethical standards that supposedly break down during the course of medical education. However, if we interpret the changes that medical students report as a process of trading lay, humanistic values for professional ones, then pushing professionalism even harder cannot be the response. To the contrary, all it does is further befuddle medical students about exactly what we seek from them.

The White Coat Ceremony

With this, we come to the White Coat Ceremony, the almost universal opening bell for American medical education, where the confusion begins. The Gold Foundation, to its credit, has bucked the trend towards professionalism and continues to identify "humanism in medicine" as its primary mission.[7] The White Coat Ceremony remains its most

visible achievement in trying to "build values and traditions through rituals and rewards that would elevate and expand humanism."[10] But what symbol does the Gold Foundation use for this purpose? The white coat, the supreme icon of medicine as a profession. In other words, we are teaching medical students that humanism is to be found within their professional identities and not outside of it, and that their white coats will provide all the encouragement they need to level with their patients as fellow humans. Through the White Coat Ceremony, the locus of humanism becomes an external uniform of exclusivity rather than the naked, vulnerable, common human being who hides inside. Not only do students miss the point of humanism in the moment of the ceremony, they also learn that their professional socialization (i.e., "putting on the coat") is a source of virtue, providing a full dose of the sensitivity, courage, and humility they will need as physicians.

Furthermore, whenever this faith falters in the future, the medical establishment repeats the message, responding to a self-reported sense of ethical erosion with a greater emphasis on competencies in professionalism. So begins a long journey for medical students of having their internal struggles between lay humanistic and professional values denied, their intuitive sense of friction unacknowledged, and their own silent transformations from humanists to professionals ever reinforced by an enshrined set of clichés and myths.

Amidst all the acclaim,[8,47] some of the problematic themes latent in the White Coat Ceremony have been recognized.[48–50] Robert Veatch[49] has been particularly sharp in his criticism of what the Gold Foundation positively describes as a "bonding process" between faculty and students.[7] Veatch charges that the White Coat Ceremony is better described as "a symbolic 'setting apart' of the student from the lay population." He concludes that

> it is doubtful that a "bonding process" is tolerable if its real function is symbolically to remove students from the culture from which they and their future patients come and to place them in a new culture bonded with medical practitioners from all manner of traditions but increasingly isolated from the people and cultures from which they have come.

What Veatch leaves out is that the ceremony is actually staged in the name of "humanism in medicine." Not only does it ritualize the conversion of medical students from lay people into professionals, but it claims that the students will be more connected with the universal values of humanism as a result.

Responding to Veatch, other authors[8,51] reject what Veatch sees as an inherent tension between personal values and professional ethics, between lay and professional culture. Thus, Raanan Gillon,[51] for instance, writes that the bonding process "is intended as an enhancement and expansion of a medical student's and a doctor's moral and cultural commitments, not a replacement of those they already have." If only it were so simple. As any medical student or reflective physician can attest, the tensions are real, deep, and systematic. If we acknowledge them, we will at least have a chance to confront them openly. With enough humility, we might even seek the input of the lay community, who arguably ought to have a say in how easily its values should bend to the whims of self-righteous professionalism. If we deny the conflict, however, we will only continue to enwrap ourselves ever more tightly in this enchanted cloak of humanism and professionalism, waiting for the public to point out that we are thinly veiled indeed.

The Legacy of Dr. Arnold P. Gold

It is unfortunate that the Gold Foundation has accidentally stumbled into the politics of professionalism, for its mission is genuine to the core. If it has done so, it is only because the white coat for Dr. Gold, it seems, symbolizes the medical tradition of 1954, when, in his words,

> There were none of the competing values and messages that are prevalent today. Residents and students did what their attendings modeled. Altruism was the rule, and meeting the needs of the patients, whatever the personal cost, was the norm. In effect, both the formal and the hidden curriculum were one in the same, and expectations for success were clearly defined.[10]

Whether the messages of professionalism were indeed so straightforward 50 years ago is itself a question, but Dr. Gold first among us acknowledges the shortcomings today. The irony, however, is that to today's medical students, the white coat symbolizes not the medical profession of 1954 but the current medical culture that compelled Dr. Arnold and Dr. Sandra Gold to launch the Gold Foundation in the first place. In other words, the Gold Foundation has gotten caught in the very gap between humanism and professionalism, tying timeless values to the whims and fancies of today's medical culture. Unwittingly, it is contributing to the socialization of students into the very professional conception that it claims has betrayed the spirit of humanism.

But there is a greater fallacy here, and perhaps Dr. Gold's model most of all can provide guidance in revealing it. If Dr. Gold became a caring physician, I suspect that it was not because he joined the professional ranks of physicians but because he trained with humanistic doctors who brought humanism to their medicine. If they encouraged and rewarded his integrity and compassion in professional contexts, all the better, but I doubt his humanism was truly rooted in his professional practice. My own hunch is that Dr. Gold is an extraordinary human—and humanist—in every sense, and I read his secretary's words carefully when she comments, "It is rare when a patient leaves Dr. Gold's office to not mention what a sweet and kind *human being* he is"[52] (emphasis added). I would venture that the outstanding model of practice that the Gold Foundation honors draws more on Dr. Gold's core person than any professional identity. This, ultimately, is the potent message of Dr. Gold's legacy that medical students so desperately need: your socialization into the medical system will hand you a mixed bag; no one besides yourself can be responsible for your development of character; and this character, on which your patients will rely, will ultimately grow out of what kind of person, not how much of a physician, you are.

We do not need to teach students how to put on their white coats, but how to take them off. If I could script an initiation ritual for medical students, it would be in the spirit of a comment by Dr. Sandra Gold, president and chief executive officer of the Gold Foundation: "One thought is that every physician in training should spend a week as a patient."[10] Rather than cloak the students in the coats of the elite, I would borrow a scene

from the 1991 film *The Doctor* and dress the students in the common garb of human frailty: a hospital gown. Vulnerable and slightly exposed, they could stand in front of a crowd that only slightly outnumbers the daily census of an average hospital room and pledge never to forget how unforgiving medical care can be in stripping patients down to their bare humanity. Perhaps students would thus embark on their medical education with a reminder of what they share with their patients rather than what sets them apart.

Conclusion: Humanism *Over* Professionalism in Medical Education

I close with a pointed message for the medical profession overall. Humanism is too precious to medicine to be swallowed up by pretentious professionalism. To the contrary, humanism must remain the external standard by which we can occasionally critique our practice and recenter our professional values. If we persist with the notion that professionalism embodies humanism, we only rob ourselves of an important reality check that can keep us grounded in and connected to the lay population we serve.

But it is not enough just to protect the universal values of humanism from an encroaching professionalism. Rather, we ought to foster a practice of medicine in which an expansive spirit of humanism that transcends the specific realm of health and disease continually animates and elevates our perspectives. Perhaps a greater emphasis on the universal principles of humanism, rather than on parochial professionalism, is in order, at least at the level of undergraduate medical education. The social, political, and economic forces that fuel medical professionalism are not going away. Furthermore, the Accreditation Council for Graduate Medical Education (ACGME) has already canonized professionalism as one of the central criteria for resident competency,[53] guaranteeing that medical trainees will soon enough encounter its themes. But, undergraduate medical education can still choose to resist the fad if it so wishes. Rather than submit to the framework that the ACGME has chosen, medical educators should place the onus on professionalism to prove what it offers to their bright-eyed, fresh recruits that a sweeping and inspiring humanism does not.

Medical schools do not need the slogans of professionalism any more than kindergartens need political banners. Nor does medical education benefit from the jumbling of disparate terms. There is nothing terribly humanistic about protecting professional elitism, whether through uniforms or other means, and to pretend otherwise risks cheapening the very concept to the point of irrelevance.

What our students could use most is the intellectual and emotional space to reflect on their inexorable transition from lay to professional, as well as validation from their mentors about that process. We serve our students best by keeping their tensions alive rather than masking them, lest these future physicians lose total self-awareness of their conflicted social role. Let them learn to subordinate their medical, professional identity to their essential human character, for our goal is physicians who see their medicine as part of a commitment to humanism, not physicians who superficially incorporate values of humanism into their picture of medicine.

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Teaching and Learning Moments

TIMI's Last Walk: Artist's Statement

The mixed-media artwork featured on this month's cover of *Academic Medicine* is a piece by Patrick Locke, a student at Westlake High School, Westlake OH. Patrick created this piece for "Cleveland Clinic eXpressions™: The Intersection of Art and Science," which uses the arts to engage high school students in the world of scientific research. The program, developed by the Cleveland Clinic Office of Civic Education Initiatives, employs project-based, peer-to-peer learning, to enable art students to interpret research conducted by classmates who have graduated from Cleveland Clinic science internships. In addition to giving students a deeper, real-world understanding of art and science, the eXpressions program also promotes creativity, innovation, communication, and teamwork.

Patrick Locke's *TIMI's Last Walk* corresponds with a classmate's research project entitled, "Evaluation of Serum BN-Peptide Levels as a Prognostic Marker in Patients with Acute Decompensated Heart Failure." Of his work, which was an eXpressions™ Blue Ribbon Award recipient, Patrick says,

> My mixed-media project is a sculpture of my own interpretation of the heart. Although my version is a tad bit "out there," it still shows the resemblance of a heart in pain and stress. The heart, besides being part of our body, is a symbol. The heart is a symbol of love, life and joy to many people. I show the heart, however, as being pressured, stressed and antagonized through harsh work and trials that the heart must undergo. The heart is, in my opinion, the most important part in the whole body. We have to keep it healthy and strong and make sure it doesn't break. For in reality our hearts do break, so we should try our best to mend them in any way possible.

For more information about the eXpressions program, please visit (www.clevelandclinic.org/CivicEducation).

Rosalind Strickland

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Editor's Note: This Teaching and Learning Moments essay was contributed as a companion to this month's AM Cover Art selection, which appears on the cover.