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Letter to the Editor

Re-examining Professional Identity Formation in Medical Education through Critical Discourse Analysis

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Dear Editor,

I am writing to contribute to the ongoing conversation on professional identity formation (PIF) and medical professionalism within the context of medical education, drawing on a critical discourse analysis (CDA) approach. As medical educators and scholars, we are tasked not only with transmitting knowledge and skills but also with shaping the professional identities of future physicians. However, the processes and discourses underpinning this formation often go unexamined, perpetuating power imbalances, biomedical dominance, and the marginalization of patient and community voices.

Discourses of objectification and commodification in clinical training

Medical trainees frequently adopt linguistic frameworks that reduce patients to biomedical categories, referring to individuals as "the leukemia in bed 5" or "the diabetic case." This patient-as-disease-category discourse aligns students with the scientific rigor expected in clinical decision-making, but also distances them from emotional engagement, reinforcing a professional identity centered on detached expertise.[1] Furthermore, a patient-as-educational-commodity discourse emerges when trainees prioritize their learning over holistic care, viewing patients as opportunities for technical skill acquisition rather than as partners in care[1]. Such discourses normalize a transactional view of medicine, with implications for empathy and ethical practice.

Institutional enculturation and the limits of reflective practice

Medical institutions explicitly shape professional identity through structured curricula and implicit norms. Accreditation bodies such as the Accreditation Council for Graduate Medical Education (ACGME) define professionalism in terms of ethical principles and sensitivity to diversity,[2] but these ideals are operationalized through epistemic rituals—such as standardized case presentations—and reflective exercises. While reflection is promoted as a tool for internalizing values like empathy and accountability, it often individualizes systemic issues, such as burnout or inequity, framing them as personal failings rather than structural problems.[3] The persistent lack of attention to social determinants—such as race, class, and gender—in case discussions reflects a broader medical ideology that frames disparities as biological inevitabilities rather than as products of socio-political forces.[4]

The hidden curriculum and social accountability

Beneath the formal curriculum lies a hidden curriculum that perpetuates professional hierarchies and marginalizes critical perspectives. Narrative erasures are common: medical students' reflective writing often omits critiques of resource inequities or institutional policies, instead attributing clinical challenges to patient "noncompliance".[3] Professional gatekeeping is reinforced through the implicit valorization of specialty prestige, shaping career aspirations and attitudes toward primary care and underserved populations. Even well-intentioned initiatives, such as rural health electives, may inadvertently frame marginalized communities as "training grounds" for students, reinforcing paternalistic norms and a savior complex.[5]

Historical shifts and the crisis of professional legitimacy

The legitimization of medical authority has evolved, with the current phase characterized by an emphasis on patient autonomy to justify clinical decisions—ostensibly shifting accountability, but in practice preserving professional authority.[1] This discourse often masks persistent power imbalances, as patients rarely challenge recommendations framed as "consumer choices". CDA reveals how medical discourse manages dissent through lexical gaps (e.g.,

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the absence of terms like "structural racism" in case presentations), passive constructions (e.g., "treatment was delayed"), and metaphorical framings (e.g., hospitals as "factories"), all of which depoliticize healthcare and obscure systemic inequities.

Toward critical reflexivity and structural competency

Reforming PIF requires disrupting the hidden curriculum and integrating explicit discussions of power, privilege, and structural determinants of health into medical training.[4] This includes:

- Embedding critical reflection on institutional power dynamics in morbidity and mortality conferences and ethics training.
- Amplifying marginalized narratives by including patient and community perspectives in case presentations.
- Prioritizing community health metrics and social accountability alongside biomedical outcomes.
- Teaching structural competency enables trainees to diagnose and address socio-political determinants of health as rigorously as they assess laboratory results.

Reflection must evolve from individual introspection to collective critical praxis, shifting the question from "How can I improve?" to "How can we dismantle oppressive systems?" Only by interrogating the discourses that shape professional identity can we move toward a model of professionalism rooted in solidarity, equity, and social justice.[4]

Conclusion

PIF is not a neutral process but a contested terrain where language and institutional norms legitimize certain identities and practices while silencing others. CDA exposes how objectivity, autonomy, and efficiency are mobilized to sustain hierarchies that conflict with medicine's egalitarian ideals. By fostering critical reflexivity and structural competency, medical educators can equip trainees to heal not only individual patients but also the systems that shape health and illness.

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