

COMMENTARY

Unmasking the professional doctor archetype

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A challenge highlighted in a recent scoping review on neurodivergence and health professional education in this journal is the normative archetype of professional doctors.¹ The review speaks about how the archetype—of a doctor who is hyper able-bodied, hyper able-minded, eternally-competent—is at odds with the identity of a neurodivergent (ND) doctor.² This commentary confronts that norm, arguing that breaking it not only empowers ND doctors but also redefines professional identity for everyone's benefit.

Archetypes are everywhere. Archetypes help create a common ideal to strive towards, an identity that unites a profession and set a standard that others can be compared to. Clinical medicine has also created an archetype, not by accident but as a product of its complex history. This archetype pictures a professional doctor, as described above, which helps doctors work hard, even do the notorious 36- and 48-hour long shifts at the hospital without complaining. It normalises long working hours, sleepless nights, packed schedules and overlapping expectations on a doctor of providing care, learning, teaching, managing, leading and researching—all without getting burnt out.

How helpful is this archetype? What harms does it create and perpetuate?

At the forefront of those who are unlikely to fit this archetype are doctors with disabilities, including those who are neurodivergent. The professional archetype expects one to be smiling and keeping strong eye contact, friendly yet not emotional, alert but not too sensitive, punctual yet flexible, independent yet dependable, working long hours yet uncomplaining. A neurodivergent doctor, on the other hand, may often find it difficult to keep smiling, hold a poker face, avoid sustained eye contact, not be socially skilled, be emotional, be alert but highly sensitive, be time blind, be dependent on others and need rest often. This misfit between what is expected of us as professionals and what we are able to be as ND doctors creates an incompatibility and identity dissonance, especially in clinical spaces where the performance of the archetype is expected to be at its best.³ The way out becomes to mask and camouflage, minimising one's own unique identity, leading ND doctors to become

exhausted and emotionally dysregulated, resulting in a vicious cycle of failure-masking/camouflaging-burnout-failure. Many such people end up dropping out of medicine or step into nonclinical or nonmedical roles as soon as they can.

A reason ND doctors have not been able to break this cycle has been because of the strict enforcement of the professional archetype in the name of competency and patient safety.³ Formally, it happens through evaluations in clinical rotations and 'fitness to practice panels'.⁴ Informally, the archetype is sustained through a "hidden curriculum" of stares, jokes and bullying through regular mundane interactions in the canteens, cafes and rest areas.⁴ Further, the enforcement happens through self-regulation by the ND doctors themselves.⁵ The enforcement is strengthened by the authoritarianism that is prevalent in many medical schools. Hierarchies and designations encode a pecking order that virtually creates a caste system within medicine. Neurodivergent doctors not only find it difficult to understand this social dynamic but also find themselves powerless and stripped of agency without the social prowess to navigate this complex system.^{5,6}

It is, therefore, not surprising that studies show that only around half of doctors with disabilities with a documented need for accommodation request them.⁷ Further, in India, for example, ND doctors do not benefit from policies available to other doctors with disabilities such as reservations or quotas.

By making it hard for ND doctors to fit the archetype and privileging those who do, the archetype is ableist.² It reinforces the idea that ND doctors, by not fitting the archetype, are inferior, deficient, impaired and need to let go of their neurodivergence to be a professional doctor. It thus shifts the focus from problematising the archetype (the social model of disability) to problematising the people who do not fit the archetype (the medical model of disability) trying to squeeze them into a singular model of how medicine can be learnt, practiced and taught. In the context of experiences of minoritised racial groups of doctors, the idea of "professionalism" has been suggested to be an "oppressive, homogenising force" meant to uphold White, male, Western standards of care.⁵ Such studies bring

valuable insights and ideas such as professional identity formation but still ignores the experiences of ND doctors where more research is needed.⁸

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To move towards a system of medicine that works for everyone—a universal design of learning and providing care—we will need to embrace the neurodiversity among us; moving away from a deficit-based model to one that recognises the strengths of ND ways of practicing medicine. Such a way would embrace individuality and self-expression rather than trying to mould everyone into a single archetype.⁵ Medicine will need to problematise and question the idea of “professionalism” rather than weaponising it to preserve a harmful status quo.

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It should instead look to unmask the archetype of the professional doctor to move towards an authentic “identity-conscious professionalism” that incorporates individual identities and differences.⁵ But what could motivate ableist health systems to make this move? One reason is the recognition by a regulatory body that a diverse workforce is needed to meet the needs of a diverse population: that ND doctors are needed to better care for ND patients.^{9,10} This is true and useful but still utilitarian. Instead, we suggest foregrounding the strengths of ND ways of practicing medicine: a heightened sense of justice and ethics, humility, egalitarian work cultures, the drive to help others, structure and predictability, the ability to stay calm under pressure, efforts to reduce sensory load of environments and prioritising restorative rest. These are characteristics that not just ND doctors value, but all doctors and service users could benefit from. It is what a health system needs to become better and cater to all its patients well, not just those who are ND. Hence, breaking the archetype of the professional doctor benefits all of us.

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AUTHOR CONTRIBUTIONS

Harikerthan Raghuram: Conceptualization; writing—original draft; writing—review and editing. **Satendra Singh:** Conceptualization; writing—review and editing.

DATA AVAILABILITY STATEMENT

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