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Greer Spradling April 12, 2022

“What You Know You Should Receive”: Comparing Staff and Student Justice Perceptions within the Medical School Environment

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Abstract

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Similar to many other workplace environments, medical schools are subject to potent status hierarchies, begging the question of how low-status members in these systems, such as students and staff, come to evaluate their situations as just or unjust. Therefore, the present study aims to build off of extant sociological literature by exploring which of the three areas of justice—distributive, procedural, and interactional—medical students and staff emphasize most, as well as examining the impact of group-based and role-based status differences on student and staff justice perceptions. Relying on fairness heuristic theory, the author also examines whether medical students and staff generalize the justice evaluations they have formulated in areas with more knowledge to evaluations in areas of greater uncertainty. In order to parse out recurring themes, the author performs qualitative data analyses on 22 in-depth interviews with students and staff members. Overall, staff members show more concern for issues of distributive justice and role-based status differences, whereas students emphasize the importance of interactional justice and group-based status differences. Both groups demonstrate tendencies to generalize justice perceptions under conditions of uncertainty. Ultimately, the present study expands justice research into the realm of medical education and presents avenues for future exploration into how low-status groups formulate and utilize their justice evaluations.

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INTRODUCTION

Evidenced by centuries of philosophical debate, particularly in moral ethics, people care greatly about what should be considered the most right or fair way to treat others. One concept that is integral to moral ethics is justice. As proposed by Plato in book four of his *Republic*, justice can be characterized as key to the harmonic functioning of a social system, whereby individuals are neither allotted more than they are owed nor denied that which they deserve. More knowledge is required, however, to address the implications of justice perceptions in more modern times and outside the dyadic realm. Thus, there is much value to research examining the mechanism(s) by which individuals make judgements about the relative justice or injustice of certain situations, as well as how individual-level or systemic factors may influence these perceptions.

The current project utilizes data from an ongoing study titled "Emory School of Medicine Towards Inclusive Excellence for Stakeholders" (ESOM TIES), whose principal investigators are Ulemu Luhanga, MSc, MEd, PhD and Dejuan White, MD. The author of the current paper has been a research assistant on the ESOM TIES project since the summer of 2021. The interviews analyzed for the current paper are a subset of the data collected prior for the ESOM TIES project, and they are explored in the hopes of gleaming insight into how justice perceptions are formed and utilized by medical students and medical school staff. Examining subjective justice perceptions (sometimes referred to as justice evaluations) has become, in more recent years, a prominent aim of sociological inquiry. Many studies have focused on the workplace environment, as this setting carries both instrumental and relational consequences for employees (Blader and Tyler 2009). Few, however, have examined the role of justice perceptions in the medical school environment, and none have compared medical students' justice perceptions to

those of others occupying relatively low-status roles in the medical school environment, namely staff.

The present qualitative study aims to increase knowledge surrounding issues of justice within the broader medical school environment, comparing across these low-status roles (student versus staff). This effort is undertaken to highlight areas where actionable solutions may be put in place to increase perceived justice within the medical school environment for all parties, especially because justice perceptions influence employees' job performance, organizational citizenship behavior, and counterproductive work behavior (Cohen-Charash and Spector 2001; Colquitt et al. 2013). The current paper extends existing literature on justice perceptions in the workplace, as well as the influence of status on differences in justice perceptions. It also augments extant literature pertaining specifically to unique environments where individuals occupy multiple low-status roles at once (i.e. employee and student). Herein, the author will demonstrate the theoretical backing for and implications of the current study by defining the three different types of justice, explaining the application of fairness heuristic theory to understanding the formulation of justice perceptions, and detailing existing research regarding the impact of status on justice evaluations.

WORKPLACE JUSTICE

According to Jost and Kay's (2010:1122) historical review of justice research and theory, social justice more broadly can be defined as:

> A state of affairs (either actual or ideal) in which (a) benefits and burdens in society are dispersed in accordance with some allocation principle (or set of principles); (b) procedures, norms, and rules that govern political and other forms of decision making preserve the basic rights, liberties, and entitlements of individuals and groups; and (c) human beings (and perhaps other species) are treated with dignity and respect not only by authorities but also by other relevant social actors, including fellow citizens.

Following this definition, there are three main types of justice that can be evaluated within the workplace and beyond: distributive, procedural, and interactional. Each type of justice corresponds to different parts of the general definition of social justice, with distributive justice being concerned with the distribution of benefits and burdens, procedural justice being concerned with the fairness of decision-making processes, and interactional justice being concerned with interpersonal respect (Jost and Kay 2010). Importantly, all three types of justice are applicable to the medical school environment. Therefore, definitions for each type of justice—drawn from extant sociological literature—and rationales for their application to medical students' and staff's experiences follow.

Distributive Justice

As previously mentioned, distributive justice (Adams 1965) pertains to the distribution of burdens and benefits within a system. Observers reach distributive justice evaluations by comparing the actual reward or burden with what they consider to be a fair reward or burden for the receiver (Jasso, Törnblom, and Sabbagh 2016). Importantly, conceptualizations of just rewards and burdens can vary depending on a host of observer characteristics, receiver characteristics, and contextual factors (Jasso et al. 2016). Although there may be many ways for individuals to reach conclusions about what the actual reward/burden and just reward/burden are, distributive justice evaluations are fundamentally based in the comparison between actual and expected allocations.

Within any workplace, distributive justice can be demonstrated most obviously by salaries. This holds true with respect to medical school staff, so the author expects that most of the conversation with staff surrounding distributive justice will center around comparisons they make between their actual compensation and how they believe they should be compensated.

When it comes to medical students, however, distributive justice must be operationalized differently, since medical students are not paid for their labor until they graduate. Since they are still in the midst of their educational career, the author expects that medical students will be concerned mostly with grades when it comes to their distributive justice evaluations. By comparing the grades they have received to the grades they expected to receive given their effort level, medical students will judge the medical school environment as either distributively just or unjust. The author predicts that grades will be the most pressing distributive justice factor for students because of how their grades are utilized in determining where/if they match to selective residency programs. Another distributive justice factor worth noting—and applicable to both medical school students and staff—is the distribution of labor. Although more nebulous to define, the author expects both students and staff to demonstrate concern in relation the divvying up of responsibility and workload.

Procedural Justice

Whereas distributive justice is concerned primarily with instrumental (material) ends, procedural justice is intimately tied to an individual's relational (social) concerns, especially as it pertains to their social standing within an organizational system (Tyler 1994). Procedural justice evaluations are based in individuals' perceptions of the fairness of processes used in decision-making (Vermunt and Steensma 2016). According to Leventhal (1980), there are six criteria that foster more positive evaluations of procedural justice: consistency, bias suppression, accuracy, correctability, representativeness, and ethicality. Consistency requires that processes remain the same across time and individual. Bias suppression ensures that self-serving gain is not one of the goals, and accuracy prioritizes the use of correct information in decision-making. Correctability allows for the ability to revisit and revise processes if they are deemed to be flawed in some way.

Representativeness centers the need to hear from all affected parties throughout the decision-making process, and ethicality requires adhering to some standard of ethical behavior (Vermunt and Steensma 2016).

Procedural justice within medical schools is often related to the processes that determine both salaries and workload aspects such as hours and patient caseload. Because the processes utilized to decide the distributions of money and responsibility are often complex and multi-faceted, it is harder to predict what aspects interview participants will prioritize or focus on. That being said, the author predicts that both students and staff will demonstrate consideration for the amount of "voice" given to them in decision-making processes (Folger, 1977). As stated in Jost and Kay (2010:1140), the "voice effect" detailed in procedural justice literature shows that individuals who are provided the opportunity to "express one's views or feelings during the course of the decision-making process" are likely to hold more positive perceptions of organizational procedural fairness. Following this logic, the author expects that those who feel they are not provided opportunities to express their opinions and feelings will be more inclined to evaluate the medical school as procedurally unjust.

Interactional Justice

Last, interactional justice is conceptualized as the degree to which individuals feel they are respected in their broader interactions, not just as they relate to decision-making (Bies 2001). Similar to procedural justice processes, the relational concerns at work in interactional justice reflect a person's standing within an organization. As formulated by Bies and Moag (1986), there are at least four characteristics of just interactions: respect, truthfulness, justification, and propriety. Within interactional justice, propriety can be understood as "sensitivity, appropriateness, and the avoidance of prejudicial treatment," whereas justification indicates "the

provision of timely, adequate explanations for decisions" (Jost and Kay 2010:1143). The idea of justification in particular sheds light on the close linkage between procedural and interactional justice. Although interactional justice may come into play in regard to how individuals communicate decisions, it is more far-reaching, not bound by a certain phenomenon like decision-making.

Within a medical school, interactional justice functions similarly to other settings, indicative of the respect and dignity with which individuals feel they are treated by others. For the current study, the author will rely on inductive thematic analysis in order to properly operationalize interactional justice in the medical school environment, presuming that this environment will carry particular nuances. The author expects that, following Bies and Moag's (1986) formulation of interactional justice, both students and staff will demonstrate attention to the presence or lack of respect, truthfulness, justification, and propriety in their interactions. The author also expects that staff and students who identify as underrepresented minorities (whether racial, gender, sexual orientation, etc.) will be particularly attentive to any microaggressions they encounter in their interactions within the medical school. As defined by Sue et al. (2007:271), microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative" attitudes towards minoritized groups. As is demonstrated by the definition, microaggressions effectively communicate a lack of respect for the victim. Thus, the author predicts that participants who identify with a historically marginalized group will show particular attunement to microaggressions insofar as they demonstrate a lack of interpersonal respect and thus a lack of interactional justice.

Although useful, simply defining and demonstrating the application of different types of justice in the medical school environment cannot explain for differences that may exist in the formulation of justice evaluations between medical students and staff. More specifically, the author aims to shed light on why medical students and staff may be more attentive to and/or place more emphasis on different types of justice—and thus less focus/emphasis on the other types of justice—due to existing differences in status and circumstance between medical students and staff. One theory that can be useful in examining these differences and positing explanations for the differential weight placed on distributive, procedural, and interactional justice perceptions is fairness heuristic theory.

Fairness Heuristic Theory — Process of Formulating Justice Evaluations

Fairness heuristic theory asserts that employees adopt a cognitive shortcut based on initial justice perceptions from which to base future interpretations of workplace fairness (van den Bos, Lind, and Wilke 2001). An important aspect of this theory is how it addresses the process by which individuals formulate justice evaluations under conditions of relative uncertainty. The part of fairness heuristic theory most relevant to the current study is what Proudfoot and Lind (2015:7) call the "substitutability of fairness information." This substitutability refers to the phenomenon whereby individuals who lack adequate information in one arena of justice place greater emphasis on other areas of justice for which they do have relevant information in order to make a more general evaluation of fairness (Proudfoot and Lind 2015).

Fairness heuristic theory is particularly useful in explaining potential differences in the weight placed on distributive, procedural, and interactional justice by medical students in comparison to administrative staff members. Medical students may not have a lot of procedural information from which to conclude whether decision-making processes are fair since faculty

and upper-level administration are typically the ones making the decisions. They also do not get paid for their labor until they graduate and become residents, so a large aspect of distributive justice is removed. As a result, they will no doubt draw their evaluations of distributive justice based on more nebulous reward and burden measures such as grades and workload. Because these rewards and burdens may be harder to quantify or compare, medical students' largest wealth of justice information will be in the interactional realm. Thus, the author predicts that medical students will focus primarily on issues of interactional justice, generalizing these perceptions to draw conclusions about distributive and procedural justice as well, due to uncertainty.

On the staff side, there will likely be more procedural information available as a function of responsibilities such as committee assignments. Because staff are paid employees, they will also have more concrete distributive information in the form of knowledge of their own salary and pay scales published by the institution. Whereas medical students interact with a plethora of people amidst their rotations (patients, residents, attendings, etc.), staff likely have smaller interaction pools in the workplace, especially if their job binds them to a particular department or office. This smaller workplace social network may result in comparatively limited interactional justice information, leading the author to expect that staff will show more concern for issues of distributive and procedural justice. If staff draw explicit interactional justice perceptions, they will likely be extensions of preexisting procedural and distributive justice evaluations.

STATUS AND JUSTICE

Outside of the impact of informational uncertainty on the weight placed on distributive, procedural, and interactional justice concerns in the medical school environment, the author is also interested in examining potential individual-level and systemic factors that result is

differential justice perceptions. Based on foundational theory (see Kemper 2006) demonstrating the emotional implications of status hierarchies in organizations, it is reasonable to infer that status surpluses or deficits conferred by group memberships (individual-level) or roles (systemic) may also impact justice perceptions for medical students and staff members.

Group-Based Status

Previous studies have shown that interactional justice is particularly important to members of historically marginalized groups (race-, gender-, and education-wise), evidenced by strong correlations between self-reported respectful treatment and job satisfaction (Henry 2011). As a facet of being numerically underrepresented within the medical school environment, women and racial minority group members are conferred less status than their male and White counterparts. Thus, the author predicts that justice perceptions in the medical school environment will vary on the basis of group-based status differences and examines existing sociological literature to substantiate this expectation.

In terms of gender, Clay-Warner, Culatta, and James (2013) argue in their review of extant literature that although there is not sufficient evidence to argue that men and women have different justice orientations, there are studies that have shown men and women may place more value on different types of justice. Results from one study covered in their review demonstrated that men placed more importance on distributive justice than women did when determining the fairness of a pay raise (Tata and Bowes-Sperry 1996). Women, on the other hand, showed more concern for the "interpersonal components of procedural justice," akin to interactional justice (Clay-Warner et al. 2013:1077). Clay-Warner et al. (2013) assert, however, that differences in sensitivity to justice and preferences for different types of justice are likely a function of status conferral, not cognitive or biological discrepancies. Based on this literature, the author expects

that medical students and staff who identify as women may prioritize interactional and aspects of procedural justice, whereas men may focus primarily on distributive justice.

Miron, Warner, and Branscombe (2011) provide a potential theoretical explanation for differing justice evaluations across racial and gender groups. Miron et al. (2011) found that Black participants required less evidence in order to deem wage inequality unfair compared to White participants, setting a stricter standard for distributive justice. In explaining what may have caused these results, Miron et al. (2011:343) theorize that advantaged and disadvantaged groups set "quantitatively different confirmatory standards in their judgments of inter-group inequality." These different confirmatory standards, they argue, are indicative of the increased sensitivity disadvantaged group members have to instances of inequality (Miron et al. 2011). Because those who are lower in status are subjected to more unjust experiences in all realms of life, they become particularly attuned to recognizing these instances of unfairness. As a result, they come to develop standards for justice that set a much higher bar than the standards of their advantaged counterparts. While limitations of the data set will not allow the author to properly draw conclusions across racial groups, one might predict based on this theoretical contribution from Miron et al. (2011) that medical students and staff from racial/ethnic minority groups would require more evidence than White participants in order to deem the organization distributively fair.

Role-Based Status

Aside from considering status conferred by social identities, it is also important to examine role-based status. In any hierarchical system, variation in social standing exists. Within the justice literature, standing has been difficult to operationalize despite its presumed impact on justice perceptions. Van Prooijen, van den Bos, and Wilke (2004) argue that standing operates in

two related, but distinct ways: standing-as-status and standing-as-inclusion. Van Prooijen et al. (2004) assert that standing-as-status is associated with how highly regarded an individual is within an organization, whereas standing-as-inclusion alludes to how well-liked an individual is within a group. Importantly, standing-as-status and standing-as-inclusion are both intimately tied to procedural justice evaluations, with studies demonstrating that both standing-as-status and standing-as-inclusion can be causally related to procedural justice sensitivity and effects as measured by satisfaction surveys (van Prooijen et al. 2004). That being said, van Prooijen et al. (2004) warn against lumping standing-as-status and standing-as-inclusion together because although increased inclusion leads to more positive procedural justice evaluations, the impact of standing-as-status is dependent on status salience.

Following the theoretical separation of standing-as-status and standing-as-inclusion in van Prooijen et al. (2004), the author of the current paper posits that, insofar as staff are more attuned to procedural justice concerns, they will also exhibit more *positive* procedural justice evaluations compared to the medical students. The author draws this conclusion based on the fact that staff are higher in standing relative to medical students despite still ranking below faculty and upper-level administration. This higher level of standing will confer both status and inclusion to medical school staff that is not afforded to the students, especially in terms of the aforementioned discussion of how medical school staff have more input in the procedural realm. As a result, the author predicts that the staff will be more likely to assess the medical school environment as procedurally fair compared to the students.

MEDICAL EDUCATION

Within the field of medical education, as well as scholarly attempts to examine and critique the medical school environment, some emerging areas of interest include diversity and

inclusion efforts within medical schools, as well as how the power and status hierarchies that are foundational to the setting may hinder these efforts. As noted by Vanstone and Grierson (2022:91), hierarchies are particularly potent within the medical school's "highly organized social context" because of the way in which "work and learning are contingent on interaction and thereby influenced greatly by social power." Although Vanstone's and Grierson's (2022) essay argues for the "productive effects" (93) of these hierarchies, they also acknowledge the common understanding of this social stratification as "omnipresent" and "repressing [low-status individuals'] ability to communicate openly and exercise their agency" (91).

This assertion of some form of duality to medical school hierarchies is not unique to Vanstone and Grierson (2022). Whether it is conceptualized as productive versus unproductive, "calcified" versus "fluid" (Vanstone and Grierson 2022), or "functional" versus "dysfunctional" (Salehi et al. 2020), much of the medical education literature points to the ingrained nature of these power structures as a function of their necessity for "optimiz[ing] patient care" (Salehi et al. 2020:906). Nonetheless, Salehi et al. (2020:906) recognize that the "dysfunctional" structures can ultimately "legitimize trainee mistreatment," creating an environment that "undermines physician empathy" and can intensify experiences of burnout and burden. Echoing Jost and Kay (2010), Salehi et al. (2020:909) also discuss the impact of power imbalances within medical education on subordinates' voice, positing that "fear of negative reactions" from higher-ups limits voice. Furthermore, they assert that voice within medical education is a function of "tenure, profession, and position," all of which are intimately tied to the existing status hierarchies (Salehi et al. 2020:909).

Based on this assertion, the author of the current paper reiterates the expectation that medical students and staff members will express feelings of relatively limited voice. Compared

to residents and attendings, medical students have been in the institution for a shorter amount of time (tenure), are not yet full-fledged physicians (profession), and are at the bottom of the food chain (position). Although the tenure piece may not hold true for staff, as many have been at the university for as long or longer than many faculty, staff voices will still be subjugated as a result of the fact that they often do not hold the same advanced degrees as faculty (profession) and entrenched in offices that are viewed as less prestigious than teaching roles (position).

Intuitively, these deeply ingrained power structures can have disproportionate impacts on certain actors within the medical school structure. In a mixed-method study of UK medical students, Broad et al. (2018:414) found that harassment and discrimination were both prevalent in the medical school environment, with 63.3% of participants having experienced one or the other. While survey data pointed towards stereotyping as being the most commonly witnessed form of discrimination, Broad et al.'s (2018) qualitative data described frequent instances of "inappropriate joking" and "invasion of personal space." They also discovered that Black and minority ethnic students, non-heterosexual students, students with disabilities, female students, and students in their clinical years all experienced or witnessed disproportionate instances of harassment or discrimination (Broad et al. 2018). Notably, only 5% of participants in Broad et al. (2020:414) declared that they had reported these instances, pointing to a perception of the reporting structures as "ineffective" and "potentially victimizing."

In her reflection on Broad et al.'s (2018) findings, Alwazzan (2018:357) claims that "learners are more likely to associate discrimination with those in power positions and who influence their career progression." This declaration provides added assurance to the prediction based on fairness heuristic theory that medical students will generalize their interactional justice perceptions to the distributive and procedural arenas. Because medical students' clinical grades

are so inexplicably tied to their social interactions with their educators and clinical assessors, it is sensible to conclude that they may view these interactions as reflective of the fairness of structures which they have less information about. Although Alwazzan (2018) does not discuss medical school staff, it stands to reason that those in power positions relative to staff—faculty and administrators—will be viewed as the originators of discrimination via the decision-making processes they oversee or benefit from, which harm or limit staff members and lead them to generalize this perceived unfairness to their interpersonal interactions.

METHODS

To examine medical students' and staff's justice perceptions within the medical school environment, the author has coded in-depth qualitative interviews conducted with ten students pursuing their MD degree at Emory University School of Medicine (ESOM) and twelve staff members employed by ESOM, specifically those employed in the MD program. Within the present study, staff members are defined as administrative employees such as program coordinators and assistant directors of various medical school offices. At the aggregate level, nine participants identified as male and thirteen as female. Since the purpose of the ESOM TIES project was to provide actionable suggestions for improvement to school of medicine leadership, the racial makeup of participants consists primarily of underrepresented minority (URM) group members. Eleven of the participants included in the current study identify as Black/African American, six identify as Asian American/Pacific Islander, and five identify as White. For students, the interviews include data from the 2021-2024 cohorts.

Student and staff participants were recruited through existing ESOM mailing lists and listservs. The email message included a document detailing the study procedures and a verbal consent form. No compensation was provided to individuals for their participation. While

sampling procedures were limited by student and staff interest in participation, a combination of cluster and stratified sampling was utilized. Cluster sampling was employed in gathering participants from the different medical student cohorts, while stratified sampling was used to recruit students and staff from different demographic groups where data was available. Importantly, because this data was only sampled from one medical school, no generalizations will be made about other medical schools or the medical school environment as a whole.

Participants offered up to an hour of their time in order to participate in the interviews, which were conducted by the ESOM TIES project's primary investigators. Example questions from these interviews included "How are/were your experiences interacting with educators/ clinical instructors? Are there any interactions that stick out? If so, why?" and "Increasingly, the school of medicine is focused on diversity, equity and inclusion (DEI). How does your program go about addressing any DEI related issues, challenges, or concerns that arise?" Though interviewers utilized a pre-decided list of questions for each session, the interviews were semi-structured in order to allow room for further discussion of specific topics and experiences brought up by participants.

Thematic analysis was performed in MAXQDA, a qualitative data software. The present study's codebook was created to address the three main justice arenas—interactional, procedural, and distributive—as they occur in the medical school environment while remaining grounded in extant literature and theory. A mix of inductive and deductive analyses were employed, which allowed for the addition of codes that were not previously considered but arose throughout the analysis process. Ultimately, distributive justice concerns included codes that applied primarily to staff (budget, pay/promotion), applied primarily to students (grades), and were deemed important by both groups of interest (professional development opportunities, workload).

Procedural justice was segmented into the six criteria proposed by Leventhal (1980)—ethicality, representativeness, correctability, accuracy, bias suppression, and consistency—with the addition of "voice." Interactional justice was broken down into the four characteristics of just interaction posited by Bies and Moag (1986): propriety, justification, truthfulness, and respect.

STUDENT JUSTICE PERCEPTIONS

Student participants discussed all three areas of justice, with significant attention paid to interactional justice concerns. In the interactional realm, primary themes included feelings of exclusion, invisibility, and discrimination, with the latter being signaled by microaggressions committed in the classroom and clinical environments. Distributively, students placed the most emphasis on the divvying out of grades and professional development opportunities, in both areas also highlighting doubts regarding the procedural fairness behind said outcomes. Lastly, analysis of student interviews also extracted the importance students placed on procedural representativeness.

Interactional Justice Concerns

As was expected, students devoted the largest amount of their attention to interactional justice, most likely as a result of it being the area where they had the greatest wealth of information from which to draw conclusions about fairness. Despite all four criteria of interactional justice—propriety, justification, truthfulness, and respect—being covered across the student interviews, participants appeared to primarily pull from examples of impropriety and disrespect when detailing evaluations of the interpersonal environment within the school of medicine as unjust.

Every student participant discussed propriety, covering all facets of Bies and Moag's (1986) definition: sensitivity, appropriateness, and lack of prejudicial treatment. Namely, more

than half of the students recalled specific instances where they experienced or witnessed educators and/or administrators make inappropriate and insensitive references to race:

> Over the course of the two weeks that I was with this attending, the one time that he went out of his way to include me in an extracurricular conversation, we had a patient whose name was Mustafa and he just, of all people, asked me if I was familiar with that name and where it comes from and blah, blah, blah. And I'm just like, "What do I and Mustafa have to do with one another?" And then he even made some references to Lion King because their main character's name or someone's name was Mufasa, not Mustafa but Mufasa and it was just like that's not even the same name. You're just trying to make weird connections on things that don't even align. And not only that, but this is the one time you actually thought to include me in something and it's only because you thought it had something to do with my Blackness and you were completely wrong. (Student 3, male, Black/African American)

Importantly, not only did instances such as this one come off as inappropriate and insensitive within the clinical environment, but they led non-White students to feel as though they were being treated differently than their White peers. Whereas White students could go about their work without fear of strange and off-putting references to their race, non-White students were subjected to harmful comments, though often off-handed, that were in actuality microaggressive in nature. The above instance is also reminiscent of the findings from Broad et al.'s (2018) qualitative data, where medical students described frequent instances of "inappropriate joking" as one of their main concerns.

Even when educators made a conscious effort to avoid biased statements, they sometimes did so in a manner that further isolated underrepresented minority students:

> When I was on the urology rotation, it was good and bad, awkward in the sense of, it was mostly a lot of White men who I was interacting with. Straight White men who were like, "Yes, we are coming from a different background." But they would get to the point where they'd be like, "Oh, we can't say that around the medical student." They were going to say something, but then they didn't. So, it felt like I wasn't fully incorporated into their service because they knew that what they were doing was not ideal. So. it's like, "Yeah, I'm glad you didn't say anything racist or sexist around me." But then I also felt I wasn't truly a part of what was going on. (Student 2, female, Black/African American)

As evidenced by the above quote, a few students experienced their educators' attempts at propriety as—counterintuitively—manifesting in another form of prejudicial treatment. Differential treatment arose nonetheless, a byproduct of residents and attendings modifying their behavior around students in an exclusionary fashion. Since this prejudicial treatment seemed to emerge only when educators were in contact with students who had different identities than themselves, it drove some student participants to draw conclusions that the medical school environment was an interactionally unfair, even at times hostile, environment.

This quote also demonstrates Van Prooijen et al.'s (2004) concept of standing-as-inclusion. Because the above participant was not included in certain conversations and jokes, her standing was automatically lowered. Ultimately, her feelings of not being "fully incorporated into their service" reflected her placement in the standing hierarchy as a less-liked individual compared to other medical students whom superiors may have felt more comfortable making biased comments around.

Besides occasions of impropriety, students also formed negative perceptions of the medical school's interactional justice based on observed respect deficits. All but two of the non-White student participants described either experiencing or witnessing interactions that were microaggressive in nature, based on Sue et al.'s (2007) definition. While many detailed specific, harmful microaggressions such as disrespectful comments made by a professor regarding a student's head covering (Student 9, female, Asian American/Pacific Islander) and the purposeful misgendering of a transgender student by fellow classmates (Student 9, female, Asian American/Pacific Islander), a few also explained a broader feeling of disrespect regarding their intelligence and worth within the educational environment:

> [Educators] would sometimes skip over me or assume that maybe I didn't maybe understand certain things, or I wouldn't get called on to answer a specific question or

> perform a certain physical exam maneuver. And initially it's just like, "Oh, it's not a big deal, they just chose someone else." But when that continuously happens, you know what I mean, when you're constantly invisible amongst the people that you're standing directly in front of, that's when you really start to clue in to it's not me, I'm not tripping. (Student 3, male, Black/African American)

Coupled with these feelings of invisibility was an impression held by a few students that the way they reacted to the environment would further influence educators' perceptions of their intellectual capabilities. For example, one student discussed how the hesitance he displayed in the clinical environment—which at its core resulted from perceived disrespect—could be interpreted as confirmatory of preexisting prejudices, when in actuality, it should've been a clue towards his feelings of mistreatment:

> I think a lot of the times those are the sorts of interactions, it was just lacking, I use the term psychological safety, right? Like lacking psychological safety in terms of feeling like I could make a mistake in this situation and not have it affect me […] You may just assume, especially if I'm a Black man or Black individual, you may just assume "Oh, this person just doesn't know it." Right? But my issue may have been that, "Oh, I was just nervous and uncomfortable with you because you never established an environment of psychological safety, you never established an environment where I feel like I can make a mistake and you're not going to critique me or you aren't going to just assume that I'm deficient because I'm Black." (Student 4, male, Black/African American)

Importantly, the above quote utilizes demonstrates Salehi et al.'s (2022:909) conclusion that the rigid hierarchies present in medical education can negatively impact subordinates' experiences of psychological safety, which Salehi et al. (2022:909) defines as "feeling comfortable to speak openly without fear of retaliation."

Crucially, and as hypothesized, students also generalized these interactional justice evaluations to the procedural and distributive realms, where they had considerably less information from which to draw informed conclusions. Because many students felt disrespected in their interactions, they presumed that the subjective evaluations employed throughout clinical rotations would reflect this disrespect in the form of lower scores. In somewhat of a snowball

effect, these procedural justice concerns then led some students to infer that they would inevitably receive unfair outcomes, barring extraordinary effort on their part to counteract the respect deficits:

> It was how I was treated that made me decide, you know what, you're going to have to go crazy […] You're going to have to go above and beyond if you want a smidgen of what you know you should receive. (Student 3, male, Black/African American)

On the whole, every student participant touched on the interactional justice elements of respect and/or propriety, illustrating the particular importance of these characteristics within the medical school environment. As an inherently hierarchical system, medical school is bound to elicit some perceived infractions of respect and propriety. That being said, it is worth noting that majority of the instances of interactional injustice detailed by students were related to group-membership differences instead of simply systematic power imbalances. Ultimately, recognizing that the root of students' procedural and distributive justice evaluations may lie in their interactional experiences assists in understanding why students perceive unfairness in regard to their grades and professional development opportunities.

Grades

As predicted, students' main concerns in the distributive realm were their grades. Every student participant mentioned the grading system at least once, and grades were the most commonly coded distributive concern across all students. Since these grades and evaluations are a determining factor for where/if the medical students eventually match to residency, it makes sense that grades would be a particularly salient distributive concern. However, although grades were the most commonly mentioned distributive concern by students, much of the conversation on this topic centered around grading *procedures* and perceived injustices therein. More

specifically, students centered a majority of their evaluations of the fairness of grading practices around perceptions of consistency and accuracy, or lack thereof.

In procedural justice literature, accuracy is achieved when decisions are made on the basis of appropriate and correct information (Leventhal 1980). When it came to standardized exams and information-based tests, students recognized that having a particularly good professor may put one student ahead of another. On the whole though, students expressed very little grievance regarding the fairness of these types of assessments. Instead, a majority of students' complaints of procedural injustice stemmed from their understanding of evaluation practices in their clinical rotations. A little less than half of the medical students demonstrated beliefs that instead of their clinical evaluations being based on competencies, they were determined utilizing other extraneous measures. For example, a few of the students discussed how they had witnessed their peers get ahead in clinical evaluations by feigning interest in a certain rotation's specialty:

> Because we take STEP, like everybody has to learn the same stuff. But in terms of navigating [rotations], like the interpersonal interactions and playing the game of "Oh, I'm interested in this specialty" so that people devote more attention to you and are more willing to teach you and are more invested in you, I didn't know about that. But some people did that. I know people who did that in every single rotation. "Yeah, I'm interested in this specialty, yeah." And they got, by their account, they got better evaluations than me. (Student 4, male, Black/African American)

Of particular note here is the belief that showing interest in a particular specialty results in the educator(s) in that specialty caring more about a student's success. Thus, of the students who had critiques about the accuracy of their clinical evaluations, a majority felt that when it came time for their educators to evaluate their clinical skills, it wasn't necessarily the skills that were reflected in their grades. Rather, their success was defined by their ability to play this ingratiating "game" to elicit their professors' attention by way of declaring interest in their realm of expertise.

Aside from displaying interest in a certain specialty to get in the good graces of evaluators, one student detailed feeling the need to go as far as to demonstrate enjoyment of similar hobbies and pastimes as their educators:

> I would do the things that I knew would get me what I wanted […] Let me read up on X, Y, Z because I know that they're interested in it even if it had nothing to do with medicine. Oh, they're talking about a TV show. Let me tap in and figure out what is this TV show about. Dumb stuff, this has nothing to do with medicine. But I know you identify with me more if I start talking to you about cooking sourdough bread, something that I don't care about or have ever done in my life. You know what I'm saying? This is playing the game. So now I can have […] braids, you know what I'm saying, be a [tall] Black man but you still feel comfortable enough to give me a good evaluation. That's how I went about it. And that was extremely taxing and sometimes I wonder if I regret it or not. (Student 3, male, Black/African American)

This student felt that, similarly to if he showed interest in an attending's specialty, exhibiting an ability to engage in conversations about educators' extracurricular interests would result in more positive clinical evaluations. Both of these implicit grading criteria—signaling enjoyment of an educator's specialty and hobbies—influenced the ways that students carried themselves in the clinical environment. Likewise, they led almost half of the students to form evaluations of clinical grading procedures as unjust, whereby "kissing up" to professors was a short-cut to good grades when, in theory, the evaluations are meant to measure clinical skills. Importantly, these unspoken criteria were particularly salient for the participants as non-White students, who already felt that their group memberships placed them at a disadvantage in the clinical environment. For marginalized students, these strategies appeared as necessary if they wished for their clinical skills to subsequently draw attendings' attention.

This differential impact on non-White students was also evidenced by a few students' discussions of grading inconsistencies. As stated by Leventhal (1980), consistency in procedural justice is a characteristic exhibited when processes used to determine a certain outcome remain the same across time and individual. Whereas students' accuracy concerns hinged on

observations of the positive impact of obsequious behavior, their discussions of consistency issues were grounded in beliefs that their identities put them at an automatic disadvantage when compared against their White counterparts:

> In my opinion, a lot of times [the difference between meeting and not meeting expectations] falls on bias. Do I identify with this person? Do they remind me of myself? Do they handle problems in the way that I think that they should handle problems even though they handled every problem that was given to them on this rotation? And then that seems to be where people make the delineation and that's, really, it's no surprise to me that Black men seem to fall in the latter because as great as we are, we have different experiences. We might choose to handle something different. It's handled and the end result is just as great as it will always be […] if not better. But it wasn't what they would have done. And so maybe that's a reason for moving someone below the line rather than above it. (Student 3, male, Black/African American)

More specifically, a few of the non-White participants felt that the lack of consistency was a reflection of how their faults were judged more harshly than those of their White classmates:

> Everybody sucks at first, but the repercussions of me, as a minority male, the repercussions of me not being good at presentations may be different from the repercussions of a White woman or a White male not being good at presentations just because of the way that I look and the fact that they perceive my faults to be more severe than these group's faults, even though we have the same faults […] I'm sure this happens to a lot of students in different ways, but again, the repercussions of that happening for me as a minority male are different from the repercussions for Katherine or Chad or Brad who the residents and the attendings see themselves in (Student 4, male, Black/African American)

Although the discussion of inconsistency is closely tied to students' procedural justice perceptions, there is a tacit connection between these procedural concerns and the aforementioned interactional justice evaluations. The notion that educators are more critical of non-White students is intrinsically tied to students' perceptions of attendings and residents as lacking propriety and respect when dealing with individuals from different backgrounds.

Professional Development Opportunities

Prior to coding, the author had anticipated that professional development opportunities would be less of a concern for students compared to staff members. However, all but two of the student participants brought up professional development opportunities as one of their main distributive justice concerns. In particular, these students found themselves comparing the quantity and quality of their professional development opportunities to those of peers stationed at different sites or under different attendings:

> It's a vascular clinic at Grady, which makes the patient population automatically more diverse than other sites, which is I think beneficial for my education […] And diverse meaning race, age, gender, even vaccination status. And other things that I can't quite remember, but yeah, all in all very beneficial to see different diverse patient populations. (Student 7, male, Asian American/Pacific Islander)

The concerns students expressed related to this unequal distribution of professional development were two-fold: (a) the lack of transparency surrounding how and why students were matched to certain places and preceptors left a lot to be desired in the justification realm of interactional justice, and (b) the lack of procedural consistency when it came to conferring hands-on experience left students worried that their grades would suffer. For example, one student recognized that it was only because she had "lucked out" on who she was assigned to that she was able to develop so many clinical skills:

> I think I personally really lucked out with my preceptor at OPEX. But I have heard very mixed things from other people. Like some people are doing, like seeing patients on their own and writing notes, that kind of thing. Doing like full physicals. Other people are just shadowing, and so there's this like wide mixture of experiences in OPEX that I feel it could be a little bit more leveled out (Student 6, female, Asian American/Pacific Islander)

Understandably, this left students who were not so lucky feeling resentful of peers that were able to get ahead because of their hands-on professional development experiences. A majority of the student participants displayed frustration that it appeared "luck of the draw" could impact such an integral part of their education. Especially when coupled with the fact that

the reasoning behind matches were not explained, it makes sense that some students would feel disillusioned to discover that some of their classmates had access to more resources and opportunities:

> I was very jealous of some other students that got placed in inpatient settings or with specialists because I felt like that gave them exposure to something that not everyone else got to, especially with the people who had inpatient experience […] It felt unfair. Then also because I was at a clinic that was not with Grady or Emory, I didn't get EMR access. So, there was very little I could do with a patient. I mean, I couldn't see what meds they were on. I couldn't see their past medical history. I could interview them, but people sometimes forget. Whereas everybody who was at Grady or Emory learned how to use the EMR, were able to access it and review charts before even going into the clinic. What a useful technique honestly for rotation, and I completely missed out on that. (Student 9, female, Asian American/Pacific Islander)

The unexpected, yet strong, emphasis that students placed on professional development opportunities affirms Alwazzan's (2018) claim that medical students are more attuned to perceived injustices they view as potentially impactful on career progression. Because students understand there to be a close link between their professional development opportunities and their grades, which in turn determine their ability to match into competitive programs, perceived discrepancies in this area are particularly salient. Ultimately, the combination of (a) recognizing the disparate levels of experience provided to different students and (b) doubting the consistency and accuracy behind grading criteria was what led medical students to draw evaluations of the medical school as distributively unjust.

Representativeness and Voice

Although consistency and accuracy were the main procedural arenas that students utilized to form justice perceptions pertaining to their grades and professional development opportunities, a majority of participants also discussed representativeness when taking a more macro-level approach to their distributive concerns. For example, one student expressed concern regarding the fact that all of the deans making decisions that would impact all students were White:

> We had a class town hall meeting, I think two, three months ago and all the deans from the medical schools that interact with students were there to talk to us. And there were I think 10 of them, and all 10 of them were White. So it was, kind of, weird […] It's not any one of them are bad at their job or anything, but I just think together when they all stand there, kind of, them in the front of the room, it kind of puts on this impression, or I don't know what the word for it is, but it's not a good feeling. (Student 5, male, Asian American/Pacific Islander)

Importantly, this sentiment ties into Vermunt's and Steensma's (2016) definition of representativeness as when a decision-making process centers the need to hear from all affected parties. Not all Emory medical students are White, and thus, only having White deans, who make decisions affecting non-White students, greatly reduces the representativeness of their procedures. Even though some students may recognize the qualifications of these individuals, underrepresented students still felt as though their voices would not be heard as a consequence of not having anyone who looked like them in positions of power.

The importance of representativeness was also illuminated by underrepresented minority students' discussion of how working under diverse pools of attendings and residents lessened some of their interactional and procedural justice concerns:

> Grady was definitely the best, but I think that's by virtue of the people who want to work at Grady. They care about Black folks. They care about underserved populations. I'm assuming they're a little bit more comfortable, like they're okay with broaching these sorts of conversations. You have more minority attendings there, more minority residents there. (Student 4, male, Black/African American)

Of note, however, is the fact that the benefits of diverse educators were only conferred to students who happened to be matched to sites such as Grady. Yet again, this highlights students' desire for increased justification and consistency in relation to rotation matching.

Surprisingly, only two of the student participants discussed the "voice effect" as defined by Jost and Kay (2010:1140). That's not to say, however, that students were not concerned with their voices being heard. Rather, students were less concerned with their own individual voices

and instead prioritized the voices of the groups they self-identified with, more in line with the procedural justice characteristic of representativeness named by Leventhal (1980).

STAFF JUSTICE PERCEPTIONS

Compared to students, staff members placed significantly less emphasis on the interactional realm of justice. Rather, staff primarily discussed their distributive justice concerns as it related to pay, promotions, and professional development opportunities. When staff did discuss their interactions, however, it was mostly within the context of having difficulty navigating the employee hierarchies and feeling as though they did not receive as much respect as faculty or administrators.

Pay and Promotions

As predicted, staff discussed distributive justice the most of the three areas of justice, hinting that staff had relatively higher levels of information and/or complaints within this realm. A majority of the staff interviews discussed pay and/or promotions (neither of which were directly asked about), and every staff participant touched on professional development opportunities (which interviewers did directly inquire about). Half of the staff participants discussed their pay and promotion opportunities, usually in comparison with their perception of faculty's salaries and advancements:

> I would say we definitely need to talk about pay equity amongst staff. I feel that it's a hush-hush or a very taboo topic. And when we think about the difference between staff and faculty, it's very uneven […] I'll give you an example. When staff are asked to participate on a committee or a task force or something is added to their role, that takes a little bit of time, percentage of their role, what they're doing daily. There is no real clear, for me, understanding or even discussion about being financially compensated for these additional roles or these additional responsibilities. Versus a faculty, if there's an additional assignment, there is financial compensation for that (Staff 2, female, Black/African American)

Strikingly, the above comment displays the internal process by which staff members' evaluations of their own outcomes as unjust can exacerbate their conclusions about the fairness of procedures and interactions. Because this staff member already deems there to be pay inequity between staff and faculty, it leads them to harshly question the integrity of the pay decision processes and the messaging (or lack thereof) about pay differences. In particular—and similarly to students—they primarily question the consistency and accuracy of salary decision making, believing that similar workload additions do not yield comparable effects on pay for staff and faculty, calling into question what determines a staff member's eligibility for a pay raise, as well as whether these unknown deciding factors are apt or simply dependent on status. As demonstrated in the above quote, distributive discrepancies can also influence a staff member's interactional justice perceptions. The distributive justice concern of inadequate compensation is worsened by a perceived lack of justification, in terms of explanation for both why and how staff members appear to be treated differently than faculty members when it comes to salaries.

This perceived lack of justification is even more apparent in staff's discussion of promotions, where a few of the participants lamented a seemingly convoluted or nonexistent upwards trajectory:

> In my head, I'm thinking of progression. I don't want to be [role] forever […] What is the next bump up? I have no idea. You know what I mean? And then how do I get there? I have no idea how many years I have to put in. (Staff 3, female, Black/African American)

Interestingly, this points to how workplace actors may use similar processes to evaluate the relative fairness of decisions as they do to assess the fairness of decisions yet to come or anticipated never to come. None of the staff detailed being formally denied promotions. Rather, those who discussed unclear trajectories held opinions that they would never receive a promotion, or if they did, that it would have to be cross-departmental. That is not to say,

however, that every staff member described wanting a promotion. For one staff member, it was less about upwards trajectory and more about receiving distributive outcomes that made her feel appreciated in her current position:

> I'm not gunning for the next promotion. I want to do my job, I want to do it well, I want to grow, I want the people I work with to appreciate me, I want to continue to get the job performance reviews, I want to be well respected by the people that I respect. But I'm not going to move on to the director of admissions at the law school. I would like to be recognized for what I do […] I'll be honest and say I'm working harder than I'm being paid for […] and it's gone on a little too long. I understand that there are many, many factors, so I'm not upset with a particular person. I feel a little taken advantage of. (Staff 11, female, White)

This discussion illuminates a distinct link between distributive justice evaluations and interactional justice evaluations, whereby staff members' feelings of injustice related to outcomes are generalized in such a way that they feel disrespected and "taken advantage of" by their superiors. Even when promotions were not sought after, staff still required pay levels that they perceived as adequate in order to feely truly respected in their work context.

Professional Development Opportunities

Out of all of the subsets of distributive justice concerns that proved applicable to staff, the one most frequently discussed was professional development opportunities. Although almost all of the staff members described participating in professional development opportunities in one way or another, a majority also relayed recognition that they had to do a lot of their own research in order to find applicable professional development opportunities and that many of the endeavors they took advantage of were provided by third-party sources instead of the school of medicine itself. Of those who expressed beliefs that there weren't enough professional development opportunities within the school of medicine, a majority pointed to a perceived discrepancy in how such events were structured and advertised towards some employees but not others:

> I don't really know much about just advancement, nor am I aware of really professional development opportunities that are pertaining to staff. For faculty, I see emails all day, emails all day for faculty to get trainings and stuff like that, but I don't see that for staff members. I guess that would be my answer is that there's a lack of a support system for staff (Staff 3, female, Black/African American)

Once again, it appears that staff members' distributive justice perceptions are less intrinsically grounded, instead being fiercely connected to their belief that staff and faculty should be treated as equals in the distributive realm. Rather than drawing on some internalized conception of the just reward as tied to their value within the system, staff members seem to adopt faculty's actual rewards as their own just rewards. Ultimately, however, the medical school power structure does not seem to honor staff members as high-status individuals in the same way that it does faculty, driving staff to draw negative interactional justice evaluations as an extension of unmet reward expectations:

> I would say that there are times as a staff person I do feel that we are kind of left on the wayside and we don't really get as much support as say, a faculty member. Support and professional development, I would say are two areas that at the School of Medicine, I don't really feel, or really have a good sense of where I fit in as a staff person. (Staff 2, female, Black/African American)

Tyler (1994) and others posit that procedural and interactional justice are the two areas most closely related to an individual's social concerns. However, these staff interviews indicate that distributive justice evaluations can also be linked with an individual's social concerns insofar as one views their received outcomes as indicative of the respect that decisionmakers have for them as fellow actors within the hierarchy.

Hierarchy Literacy and Respect

When it came to interactional justice perceptions, staff members primarily discussed them through the lens of how the medical school employee hierarchy affected their ability to perform their duties. Most prominently, a third of the staff members discussed their difficulties

understanding and navigating the hierarchies, as well as the respect deficits they encountered while traversing said systems. For example, one staff member detailed feeling overwhelmed about the number of processes at Emory and how little information they had been provided to maneuver them:

> There's so many different departments and knowing who to talk to or who to go to for this, or just having a general knowledge I think would be a big step in helping to support. Especially if someone's new coming in. A lot of times it feels like it's just kind of thrown in and you don't really know who to talk to for certain things. There's a lot of different processes at Emory and not knowing that can really make your job more difficult. So, that type of support is needed. (Staff 2, female, Black/African American)

Despite focusing a lot on the labyrinthine nature of employee hierarchies and chains of command, staff touched on their interactional justice perceptions primarily in relation to how the complex hierarchies led to unsatisfactory levels of respect:

> That hierarchy, it's like, I don't know... I'll give you an analogy. I feel like it's like when you're a young adult and still living at home, where your parents treat you like a child sometimes when they want you... When they remind you that you're still under their roof. (Staff 1, female, Black/African American)

Of the different facets of interactional justice, staff members concentrated their discussion most heavily on issues of respect. Because a lot of these interactional justice evaluations appeared to be generalized from distributive justice perceptions, it makes sense that the category of respect would be the easiest to pinpoint. Whereas propriety, justification, and truthfulness are much more apparent in true dialogue, respect can be viewed as more intangible and implicit. In the above quote, respect is described as a "feeling" rather than a more cut-and-dry evaluative measure, a sense that is gathered as much from the reverberations of the status-imbalanced environment as from strict interpersonal evidence.

UNEXPECTED FINDINGS

Throughout analyzing both the medical student and staff interviews, some unexpected themes emerged. Both student and staff participants mentioned instances of relying on individuals of the same status level to vent complaints to, characterized herein as reciprocal emotion management (Lively 2000). Additionally, Asian American and Pacific Islander students brought forth concerns regarding how the school of medicine decides who is classified as "underrepresented in medicine." Of particular note, groups also discussed the influence of cultural capital on success within the medical school environment.

Reciprocal Emotion Management

Aside from the hypothesized patterns, an unexpected finding that emerged from both the student and staff interviews, although it was only discussed by a few student and staff participants, were examples of reciprocal emotion management, a term coined by Lively (2000:34) and defined as "horizontal coping strategies of similar others that arise in response to the instrumental demands of their jobs and their interpersonal relationships with status superiors." For students, this phenomenon arose in response to instances of interactional injustice at the hands of attendings and residents:

> I think whenever [bias incidents] happened, I mentioned earlier, I shared it with some of my classmates and they're all so supportive and helpful and, yeah, I think it just creates a good community and even if it's this person's doing that everyone else recognizes it's not okay and they're not going to do that. (Student 10, male, Asian American/Pacific Islander)

When injustice occurred via interpersonal interactions with higher-ups in the medical school, a few students described leaning on each other for support. In comparison to vertical coping strategies such as formal complaints, the horizontal strategy of reciprocal emotion management can create cohesion insomuch as airing their complaints allows students to feel more connected in shared frustration. For staff members, on the other hand, reciprocal emotion

management came up in discussion of committee assignments, specifically referring to the perceived redundancy of said assignments:

> In terms of the redundancy, again, I feel like I just talk to people about it and try to get support from people who are feeling similarly (Staff 1, female, Black/African American)

Similar to the students, a few staff members described going to coworkers of the same standing to air their complaints. Thus, staff members leveraged their support network of similar-status individuals in order to cope with frustrations aimed at those higher in administration who decided their committee assignments. Based on the fact that hints towards reciprocal emotion management were detected in both the student and staff interviews, this warrants more in-depth analysis into the role this coping strategy plays within the medical school environment.

Defining "Underrepresented in Medicine"

Another interesting topic to surface throughout interviews, specifically those with students who identified as Asian American/Pacific Islander, was frustration with how the medical school went about classifying students as either overrepresented or underrepresented in medicine. One student detailed their understanding of how administration delineated these categories, explaining:

> An underrepresented minority in medicine would be like Black medical students or Latino medical students, but it's weird because I'm like, "Okay, you say underrepresented minority," but then they define that, right? They define that within the office. Then for me, I'm like, "Okay, well, I understand, I'm not an underrepresented minority as an East Asian, but what about Southeast Asian?" That is an underrepresented minority, but you don't do anything for them. What about like queer students? We don't know what the number of that is. You don't do anything for that. I think there's just a lot of this feeling of falling in this gap of we're neither majority or minority and then it's like, "Oh, so we don't care." (Student 5, male, Asian American/Pacific Islander)

Akin to the invisibility other non-White students recalled experiencing in the medical school environment, Asian American/Pacific Islander students appeared to experience a lack of voice as a result of being characterized as "overrepresented in medicine." As some pointed out,

however, numbers don't always map cleanly onto experiences. Whereas student-groups for Black and Latinx individuals were asked to participate in educational events and advocate for themselves, Asian American/Pacific Islander students recalled being left out of such activities. Notably, the technicality of admitting a large number of Asian American/Pacific Islander students doesn't erase the fact that these individuals still face discrimination as a result of their race both in the classroom and in broader society:

> Our dean of admission, during our orientation, he gives this talk about our demographic of our class and he was like, "Oh yeah, we're so diverse. We have the highest number of people of color this year, et cetera." Then he started naming them, he was like, "There's like 40 something Black students, there's nine Latino students, which is the most we've ever had, and we have a bunch of White and Asian students." I think just hearing that was a very jarring beginning […] It set the tone for a lot of us in the beginning of how the admin felt about Asian American students specifically of like... First of all, it's like, "Oh, they are overrepresented so we're just going to lump them with the White people." (Student 5, male, Asian American/Pacific Islander)

The nuances of how students are labeled or not labeled as underrepresented minorities warrants future research into the impact of such labels. More specifically, this finding necessitates exploration of if/how formalized "underrepresented" labels provide minority groups with more opportunities to exercise their voice in regard to procedural justice concerns.

Cultural Capital Deficits

Lastly, an emphasis on the importance of cultural capital for success within the medical school environment emerged from both student and staff interviews. According to Bourdieu (1973:73), cultural capital can be understood as the "instruments for the appropriation of symbolic wealth." Bourdieu's (1973) foundational work also asserts that, rather than being randomly distributed, cultural capital is instead passed down from generation to generation in "the inheritance of cultural wealth." As it relates to the medical education environment, cultural capital can work to further disadvantage students who identify as first-generation college

students or who come from families without any other doctors. These students enter medical school without the insider knowledge (cultural capital) that is afforded to many of their counterparts who come from more affluent or educated families.

A majority of student participants and a few staff participants discussed how their lack of cultural capital when entering the medical school put them at a disadvantage compared to those who had previous experiences in medicine or who had family in the field. For students, this manifested primarily as a recognition that peers who had parents in the medical field were better equipped to navigate the Emory system:

> I felt that Emory was a place best suited for students who already had parents in medicine. It felt like a place that fostered people who already had things going for them […] Emory was a place that set it up very comfortable if you had the connections already, but if you didn't, they tried to make you feel like you didn't need to worry even though that wasn't the case. (Student 1, male, Black/African American)

This quote is particularly reflective of evidence from DiMaggio's (1982:198) study of cultural capital and school success, which showed that "well-educated" parents passed down between thirty and sixty percent of their cultural capital to their children. Although DiMaggio looked at cultural capital more broadly and within high school students, it follows his and Bourdieu's logic to presume that having parents in the same profession as their children would provide said children with specific knowledge—whether related to etiquette, trajectory paths, or how to access useful social networks—that would not be afforded to students like the one above who don't have parents or extended family already working in medicine. It is also important to point out, however, that DiMaggio's (1982) results also demonstrated the possibility for cultural mobility, whereby students who are not born into culturally wealthy families can increase their cultural capital throughout their educational careers.

Students also described how this perceived cultural capital deficiency could not be assuaged simply by message statements or initiatives, especially as it related to the systematic disadvantages that underrepresented minority students faced. At the end of the day, words alone weren't sufficient to address the staggered capital at the time of matriculation, and even once students assimilated into the medical school environment, that did not guarantee that they felt able to tap into said cultural capital:

> My lived experiences of being a woman, being Black, being queer, being first generation […] All of those things have explicit difficulties when it comes to education. When it comes to all the missions that folks talk about, that lecturers or faculty may say about race or gender in lectures. But then there's also, I guess, the internalized idea of me feeling I am behind because I don't have the resources or the experiences that other people do. And I don't feel like I don't have access to those things. (Student 2, female, Black/African American)

This quote seems to run contrary to DiMaggio's (1982) formulation of cultural mobility, especially when considering how a student who has reached one of the most rigorous levels of educational attainment still feels as though there is a barrier to accessing the cultural capital that she witnesses others take advantage of. Perhaps, this is indicative of the compounding effect that group-based status differences had on cultural capital deficiencies. Non-White students already felt out of place in largely White medical school settings, and this feeling of distance was further stretched when coupled with recognition of disparate cultural capital levels.

Though staff members focused less on the generational accumulation of cultural capital, they still described experiencing a lack of knowledge about unspoken and untrained practices, such as who to carbon copy on an email. Often, these experiences left staff feeling in the dark about how to conduct their work within such a strict, yet convoluted hierarchy:

> Some people have the inside scoop on things. I walked in blind, and that's why I feel like I'm missing something because I don't fully understand the politics behind things […] There's been times where I did things with good intentions and it backfired, that's the best

> way to put it. And it's because I didn't understand the politics behind things. (Staff 3, female, Black/African American)

One staff member also touched on the usefulness of cultural capital in the realm of promotions, one of their significant distributive concerns. Essentially, those who entered their careers in the medical school with pre-existing cultural capital were provided the tools to more easily navigate *and* advance within the power structure:

> If I'm married to a doctor, maybe it gives me a little insight into the trajectory. I know the lingo. I know the language. (Staff 11, female, White)

Given this emphasis in both student and staff interviews on the importance of cultural capital, future studies should examine how cultural capital discrepancies influence outcomes, as well as what interventions could potentially balance out the playing field for students and staff who enter the medical school environment without previous experience or without generational ties to the industry.

DISCUSSION

Although many sociological studies have focused on justice within the workplace environment because of its impact on employees' job performance, organizational citizenship behavior, and counterproductive work behavior (Cohen-Charash and Spector 2001; Colquitt et al. 2013), few have compared justice perceptions across different, but similarly low-status, groups functioning within the same system. The current paper demonstrates how the emphasis placed on different areas of justice—distributive, procedural, and interactional—varies as a function of the justice information provided to different groups. Despite both serving as low-status groups within the medical school hierarchy, medical students' and staff's justice information varied greatly as a result of the structuring of their roles. In line with Blader and Tyler (2009), the workplace environment carried both instrumental and relational consequences

for both students and staff. However, the differential emphasis placed on either instrumental or relational concerns was closely linked to which area of justice contained the most information and examples for each group—distributive justice for staff and interactional justice for students.

As was predicted, the main difference between student and staff justice perceptions was the area of justice they emphasized most. Whereas staff focused primarily on their distributive justice evaluations, students chiefly highlighted their interactional justice evaluations. Despite these differential levels of importance placed on the three arenas of justice, students and staff greatly overlapped when it came to what subsets of these arenas that they showed the most concern for. Both students' and staff's leading interactional justice concern was respect, and both groups' dominant procedural justice concern was consistency. Although grades were the chief distributive justice concern for students, their second most prominent concern was professional development opportunities, which was the lead concern for staff.

Importantly, the different priorities demonstrated by students and staff may also be a function of the relative permanence or impermanence of their roles. Students most likely view their role as relatively temporary, as they will graduate from their student role to the higher-status resident role after finishing their four years of medical school. Thus, it makes sense that their distributive justice concerns would center around outcomes that determine their ability to make it to that next level (grades and professional development opportunities). Likewise, because students view their current placement in the medical school hierarchy as a transitory one, interactional justice concerns become more pressing insofar as they have the most long-term (emotional) impact compared to procedures and outcomes viewed as fleeting. Staff, on the other hand, most likely anticipate remaining in their position for many years. As a result, distributive concerns are brought to the forefront, as outcomes such as pay and promotion carry long-term

consequences for their life outside of work, such as staff members' ability to support family members.

The current study also supports the substitutability of fairness information (Proudfoot and Lind 2015; van den Bos, Lind, and Wilke 2001), by showing how informational uncertainty leads both medical students and staff to generalize their justice evaluations across justice areas. For students, this was evidenced by procedural and distributive justice perceptions that were derived initially from interactional justice evaluations. For staff, this was reversed, with distributive justice evaluations informing interactional justice perceptions. As expected, both groups drew from the justice areas in which they had the most information in order to draw conclusions about justice areas where they received less direct or tangible input, instilling a situation of uncertainty.

One noticeable difference between the student and staff interviews was who they compared their outcomes to in order to conceptualize just rewards. Both groups followed the theoretical framework discussed in Jasso et al. (2016) dictating that observers reach distributive justice evaluations by comparing the actual reward or burden with what they consider to be a fair reward or burden for the receiver. That being said, as is predicted by Jasso et al. (2016), these conceptualizations of just rewards varied depending on role-based contextual factors. Whereas staff were often siloed within offices and departments that left them with few horizontal comparisons, students were submerged in large cohorts of similar others. Thus, students relied on intra-status-group comparisons (between other students) in order to conclude what grades and professional development opportunities they deserved, staff implemented inter-status-group comparison (between staff and faculty) as their primary function to determine what pay and professional development opportunities they felt entitled to. This may also explain some of why

staff members expressed intense frustration following their conclusions that pay and professional development outcomes were unjust. Staff were not relying on comparable others in their observations, inherently widening the witnessed differences and exacerbating the emotional impact of the disparate outcomes.

The current paper also exhibited how Leventhal's (1980) criteria for procedural justice and Bies and Moag's (1986) characteristics of interactional justice are both at work within the medical school environment, though not all criteria and characteristics were weighted evenly. Of the procedural justice criteria—consistency, bias suppression, accuracy, correctability, representativeness, and ethicality (Leventhal 1980)—all but ethicality were discussed. Across student and staff interviews, the most emphasis was placed on representativeness and consistency, pointing towards their particular importance within the medical school context. When it came to the interactional justice characteristics—respect, truthfulness, justification, and propriety (Bies and Moag 1986)—all were discussed. However, there was an overwhelming prioritization of respect, more consistent with Jost and Kay's (2010) broader definition of interactional justice as being concerned with interpersonal respect. For staff in particular, interview data appeared to echo quantitative data by Henry (2011) that showed strong correlations between self-reported respectful treatment and job satisfaction, as staff members demonstrated substantial frustration over feeling disrespected in comparison to faculty.

Another notable difference between student and staff justice perceptions within the medical school environment was the extent to which participants viewed perceptions of injustice as being either role-based or group-based. Few staff espoused beliefs that their own identities (race, age, gender, etc.) were the root of distributive, procedural, or interactional injustice. Rather, they pointed most heavily to the status deficiency associated with their role as a staff

member in a hierarchy that favors faculty and administrators. Alternatively, many students held firm suspicions that their group memberships were at least partial contributors to their perceived injustices, even if only on a subconscious or implicit level.

Because there were very few White participants, it was difficult to discern whether the confirmatory standards of justice for non-White participants were truly stricter than those of White participants, as would be predicted by Miron et al. (2011). Even without adequate comparison data, however, there were extensive examples, particularly within minority student interviews, pointing towards Miron et al.'s (2011) idea that disadvantaged group members become particularly attuned to recognizing instances of unfairness, at least in the interactional realm. All but two of the non-White student participants described either experiencing or witnessing interactions that were microaggressive in nature or made assumptions about individuals based on social characteristics, supporting both the quantitative and qualitative findings from Broad et al. (2018). Only one of the non-White staff members, however, described feeling as though their identities influenced how others treated them within the medical school. Contrary to expectations, non-White staff members did not discuss many instances of feeling discriminated against or mistreated on the basis of social characteristics. Rather, they highlighted primarily role-based respect deficits.

Initially, based off of the theoretical separation of standing-as-status and standing-as-inclusion by van Prooijen et al. (2004), the author predicted that staff members would draw more positive procedural justice concerns than students because of their ranking above students in the broader medical school hierarchy. This did not seem to hold true though, as staff members didn't appear to consider students as part of the same hierarchy as themselves. Rather, staff viewed their own standing through the lens of an employee-specific hierarchy that ranked them at the

bottom, leading to evaluations of relatively low inclusion and status compared to faculty and administrators.

Gender was discussed in very few of the student and staff interviews, and when it was discussed, it was almost always in tandem with issues of race. Contrary to Tata and Bowes-Sperry (1996) and Clay-Warner et al. (2013), the current study did not find any notable differences in the emphasis that men and women placed on the different areas of justice. Perhaps, this is because gender was not a particularly salient identity within the medical school environment. As published on the Emory University School of Medicine website, the most recent cohort of medical students was comprised of over twice as many women than men (MD M1 Class Profile Fall 2021). Thus, women who are marginalized in broader society based on their gender may not have felt as marginalized within the medical school environment due to their larger numbers, lending other factors to become much more salient. This may hold particularly true considering the most recently released data from the Woodruff Health Science Center showing that only a fourth of the 2020 Emory University School of Medicine student cohort were underrepresented minorities, hinting that race may have been one of these more salient identities (At a Glance 2020).

LIMITATIONS

There are a few limitations to this paper that are worth noting, most of which are related to the sample. For one, working within an existing project that has broader goals resulted in relatively small sample sizes, only ten student interviews and twelve staff interviews. Because of this, it is unlikely that true saturation of the medical student and staff population was achieved. Thus, conclusions about these groups as a whole must be understood as potentially incomplete. Likewise, there were relatively low sample numbers for some of the subgroups of interest.

Although there were at least ten student and staff interviews from which to draw meaningful comparisons, as well as a somewhat even distribution of men (9) and women (13), there were much smaller numbers for racial subgroups. Thus, it is imperative to consider comparisons across racial groups as exploratory. The last sample-related limitation was the fact that participants were gathered from only one university, Emory University. Because of this, the conclusions are not generalizable to other universities or medical education as a whole.

The remaining notable limitation to the present endeavor was the inability to determine the interview questions. Once again, since the data utilized in this paper was preexisting, a majority of the interviews had been conducted prior to the beginning of the author's analyses. For the sake of consistency, interviews conducted after the start of this paper kept the same interview questions. Although this may be considered a limitation, it is of note that every participant spoke about their own justice perceptions—either explicitly or implicitly—despite only one or two questions focused around issues of diversity and inclusion.

FUTURE DIRECTIONS

Although there is much to learn from comparing staff and student justice perceptions because of their similarities as low-status roles within the medical education context, future studies should examine these groups separately in order to parse out all of the nuances that the occupiers of these two roles face. Future research endeavors should also aim to gather more representative samples—in terms of gender, race, and any other factors suspected to impact results—in order to be able to draw more substantive between-group comparisons within the medical school environment. The unexpected findings of the current study also suggest a need for further scholarly exploration into topics such as how reciprocal emotion management functions within the medical school environment, how cultural capital influences success for

medical students and staff, and how messaging around underrepresented-ness impacts the experiences of those considered marginalized in broader society but not within the context of medical education.

Besides looking at larger samples, more representative samples, or exploring different topics, there are also avenues opened by the current study for future scholars to examine the author's findings in more depth. For example, findings from the current study pertaining to the frequency and potency of microaggressions within the clinical environment necessitate thoughtful consideration of how to combat these incidents of bias. Likewise, these results warrant investigation into the emotional impact these instances have on both victims and observers, as well as the function that emotion plays in interactional justice evaluations more broadly. Staff findings regarding the importance of pay and promotions in relation to distributive justice concerns also point towards a need for further analysis of the impact that pay inequity and promotion stagnation have on staff attrition and job satisfaction.

Finally, additional research on medical student and staff justice perceptions should inquire about the replicability of the current study's findings and determine what conditions could cause variation in said results. For example, do students still prioritize interactional justice and do staff members still prioritize distributive justice at other universities? Or, what about conditions of relatively less uncertainty? Does providing adequate information to staff and students in all justice arenas mitigate generalizations of evaluations of the environment as unjust? Ultimately, there is still much to be explored when it comes to justice evaluations in the medical school environment, especially as it pertains to students and staff members who occupy low-status positions within this hierarchy.

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