White supremacy culture and the assimilation trauma of medical training: ungaslighting the physician burnout discourse

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ABSTRACT

The physician burnout discourse emphasises organisational challenges and personal well-being as primary points of intervention. However, these foci have minimally impacted this worsening public health crisis by failing to address the primary sources of harm: oppression. Organised medicine's whiteness, developed and sustained since the nineteenth century, has moulded training and clinical practice, favouring those who embody its oppressive ideals while punishing those who do not. Here, we reframe physician burnout as the trauma resulting from the forced assimilation into whiteness and the white supremacy culture embedded in medical training's hidden curriculum. We argue that 'ungaslighting' the physician burnout discourse requires exposing the history giving rise to medicine's whiteness and related white supremacy culture, rejecting discourses obscuring their harm, and using bold and radical frameworks to reimagine and transform medical training and practice into a reflective, healing process.

PHYSICIAN BURNOUT DISCOURSE AND ITS ERASURE OF OPPRESSION

Physician burnout, a work-related syndrome characterised by emotional exhaustion, reduced personal accomplishment and negative attitudes towards patients, affects over 50% of providers across specialties and training stages. It is also associated with depression and suicide (West, Dyrbye, and Shanafelt 2018; Menon *et al*. 2020). Excessive workloads, inefficient work processes and organisational support structures are considered key drivers. Proposed solutions, accordingly, emphasise organisational efforts, like supporting work–life integration and appointing Chief Wellbeing Officers, and individually focused solutions, such as mindfulness and self-compassion (West *et al*. 2016; West, Dyrbye, and Shanafelt 2018). Unfortunately, these interventions have minimally impacted a public health crisis that has only worsened during the COVID-19 pandemic because they fail to address primary sources of harm (Hartzband and Groopman 2020; Amanullah and Shankar 2020). Medical training is an abusive experience that disproportionately mistreats sexually and racially minoritised students (Hill *et al*. 2020). According to a 2018 report, female medical students were 220% more likely than non-STEM students to have faced sexual harassment from faculty or staff. It concluded, "many features of the medical profession, including its historical male dominance, strong hierarchies, and culture that [tolerates] mistreatment [increase] the risk of sexual harassment in the workplace" (National Academies of Sciences, Engineering, and Medicine, 2018). After training ends, the mistreatment persists, the unremitting gender pay gap and minority taxation being but two examples how (Mensah *et al*. 2020).

These findings expose oppression (see online supplemental table S1 for bolded terms' definitions) as a defining feature of the medical profession that the physician burnout discourse obscures. Systems of oppression—such as racism—are the historical, organised patterns of mistreatment cemented into culture, society and laws, and subjugating marginalised social groups while elevating dominant ones (National Museum of African American History & Culture 2019). They overlap, exacerbating one another, and compounding discrimination, a phenomenon called intersectionality (Crenshaw 1990). Medicine's own intersecting systems of oppression represent an abusive system of power in which the domination, idealisation and normalising of white able-bodied cisgender, heterosexual men depend on the subjugation, pathologising and exploitation of all others (Hooks 2010; Boyd 2019). Medicine's toxic power dynamics and steep professional hierarchy shaping training and clinical care perpetuate marginalisation while bolstering its intertwined matrices of oppression, including ableism, cissexism, classism and sexism (Vanstone and Grierson 2022). While acknowledging them, this paper highlights the trauma medical students and residents experience when forced to assimilate into medicine's white supremacy and related white supremacy culture.

CONSTRUCTING WHITENESS AND WHITE SUPREMACY IN MEDICINE: HISTORICAL PERSPECTIVES

During the mid-nineteenth century, medical schools embraced a white supremacist belief in black inferiority and subhumanness. Racism was a social sport upper-class men played to solidify a professional identity rooted in whiteness (figure 1). These heinous 'educational' activities included torturing enslaved black people with 'experiments', grave-robbing their bodies from cemeteries and attempting to detect whether they were faking illness while torturing them as 'treatment' (Willoughby 2016). This white supremacy persisted long after legalised slavery ended. The 1910 Flexner Report closed five of the seven black medical schools, preventing 35 000 black physicians from graduating in subsequent decades, amidst deadly black–white health inequities (Campbell *et al*. 2020). The American Medical Association (AMA) sanctioned this disregard for humanity, banning black physicians from local AMA chapters through the 1960s, thereby denying licensing, board certification and hospital privileges (Baker *et al*. 2008). This anti-black racism was nothing new. During the early twentieth century, organised medicine cultivated a symbiotic relationship with the Ku Klux Klan, promoting its white supremacist conceptions of race, gender, and sexuality and their related violence (Antonovich 2021). White psychiatrists diagnosed black men protesting during the Civil Rights movement with a dangerous 'protest psychosis'. Pathologising black people's resistance to oppression while normalising white people's violently oppressive behaviour is a long historical arc. It is reflected in diagnoses like drapetomania from the mid-nineteenth century and the overdiagnosis of conduct disorder in racially minoritised children today (Metzl 2010).

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Figure 1 College of Physicians and Surgeons 1902 Anatomy Class Photograph. School of Medicine Vertical Files. Historical Collections, University of Maryland, Baltimore. This photograph is being shared with permission from Tara Wink, Historical Librarian and Archivist at the Health Sciences and Human Services Library at the University of Maryland, Baltimore.

Thanks to the overwhelmingly white cisheterosexual male leadership among national organisations, department chairs and medical school deans, the white cisheteropatriarchy remains entrenched (figures 1 and 2). Testing practices, including the medical college admission test (MCAT), and honorary societies like Alpha Omega Alpha (AOA) cement the white supremacist professional taxonomy fabricated two centuries ago (Gaufberg *et al*. 2010; Rivara *et al*. 2021; Brooks 2015). As a result, in 2021, white male editors leading a top medical journal can still deny racism's existence (Rivara *et al*. 2021). Concepts like 'professionalism' cloak the policing of minoritised individuals forced to suppress their distress while enduring the profession's pervasive whiteness (Gaufberg *et al*. 2010; Sethuraman 2006). Medical education still promotes race and gender as biological, not social, realities, despite the resulting harm patients endure (Rivara *et al*. 2021).

Figure 2 Brigham and Women's Hospital to Disperse Portraits of Past White Male Luminaries. 2018. Photo by Pat Greenhouse/*The Boston Globe* via Getty Images. Published with permission from Getty Images.

MEDICAL TRAINING AS ASSIMILATION TRAUMA

Indoctrination into the medical profession is a socialisation process mediated through the hidden curriculum, which is intimately intertwined with white supremacy culture (Gaufberg *et al*. 2010; Brooks 2015; T Okun, 2021). This surreptitious process begins early when caregivers expose children to narratives glorifying medicine's social status, heroism and financial security. As a result of this grooming process, pre-med hopefuls invest exorbitant amounts of time and money to secure medical school admission (table 1), a highly competitive process that fuels a narrative of exclusivity (Lanning 2018). Not surprisingly, the majority of medical students worldwide come from affluent and elite educational backgrounds (Shahriar *et al*. 2022; Steven *et al*. 2016; Khan *et al*. 2020). Class privilege facilitates their admission and endows them with white supremacy culture's most valued skills. Classism, thus, primes affluent students to acculturate to medical culture more expeditiously, while further marginalising students from more impoverished backgrounds (Beagan 2005).

Medical school commences with senior personnel transmitting the hidden curriculum of saviourism, perfectionism and submission to hierarchy through social activities, like the white coat ceremony (Mahood 2011). Dialogue about medicine's interlocking systems of oppression and the hidden curriculum as a conduit for white supremacy culture is noticeably absent. The honeymoon period ends as the taxonomy of value based on students' ability to achieve white supremacy culture's ideals emerges (Gaufberg *et al*. 2010; Brooks 2015; Okun 2021). Students embody its toxic and divisive power hoarding and competitiveness, sense of urgency and obsession with scientific objectivity—all in order to survive (table 1) (Okun 2021). This acculturation process constitutes an assimilation trauma, one devaluing the pre-medical

Table 1 Grooming and reinforcement strategies and white supremacy culture characteristics promoting assimilation according to training stage

Training stage	Grooming strategy: methods authority figures use to prime students and residents to assimilate	Reinforcement strategy: hurdles students and residents have to traverse to prove their willingness to assimilate into medical culture	White supremacy culture characteristic: aspect of this culture that is cultivated through hidden curriculum
Pre-med	Idealised narratives about medicine's social status and prestige; competitive application process with limited spots—scarcity enhances desire for attainment; no disclosure or informed consent regarding the risk of abuse, mistreatment, depression or suicide during training	Exorbitant financial investment in applications and travel for interviews; similar investment (financial and time) preparing for and taking the MCAT	'Perfectionism' (students are conditioned to believe they can attain perfection based on the oppressive/white supremacy culture standards set by their medical schools—eg, GPA and MCAT scores create an illusion of likelihood of success/failure in medicine based on aptitude, rather than assimilation into whiteness)
Pre-Clinical years (1/2)	Organised group bonding activities, like cadaver dissection, orientation boot camps and white coat ceremonies. Little to no emotional support or emphasis on relational/communication skills; no instruction regarding the various forms of oppression undermining medical education and training	Countless hours invested in memorising 'scientific facts', all in preparation for the Step One board examination, a single exam and primary factor determining residency placement; having to master (rather than interrogate) the scientific racism embedded within clinical algorithms and practices to perform well on tests; adhering to 'professionalism'. Standards rooted in whiteness by adjusting speech, clothing, hair, and denying the existence and importance of personal lives, health and well-being, and emotional expression	'Objectivity' (assigning value to the 'rational' while invalidating or shaming the 'emotional', even though the former is the latter wrapped up in fancy logic and language; refusing to acknowledge the ways in which objectivity is used to protect power—eg, little to no antiracist/anti-oppression education about the history of medicine and scientific racism); 'perfectionism' (mistakes are seen as personal, reflecting badly on the person—eg, not passing an exam due to illness or a personal matter is configured as inadequacy as a future physician)
Clinical years (3/4)	A sense of exclusivity, specialness and superiority cultivated through special access to patients, surgical theatres and hospitals through badges, keys, pagers and membership on clinical teams; professional rituals for doctors only, like grand rounds and 'M&Ms'; donning white coats and surgical scrubs, using stethoscopes and other medical tools and technologies requiring specialised knowledge	Never-ending grading/assessment (shelf and step exams); expectation to constantly impress superiors, not strengthen teams or help patients heal, to stay late and not get enough sleep, to engage in menial, demeaning tasks to condition obedience, not develop skills ('scut work'), to ensure rapid-fire public questioning intended to humiliate, not teach ('pimping'); limited emphasis or value for bedside manner or patient advocacy; no pedagogy about antiracist clinical care or eliminating racial health inequities; no efforts to prevent racist abuse; suppressing any requests for rest, healthcare or self-care (even bathroom breaks or stopping to eat or drink water) all to prove invincibility	'Fear' (fear of not being good enough for senior physicians leads to fearing and hating others, including fellow students); 'one right way' (students are forced to embrace biomedicine/medical culture and submit to degrading 'scut work' and 'pimping' otherwise senior physicians will evaluate them poorly); 'individualism' (valuing competition more highly than cooperation, little investment in developing collaborative skills—eg, a shelf exam score, not supporting a colleague or patient, dictates your grade); 'denial' (denying the ways in which racism and white supremacy show up on the wards—eg, no antiracist clinical standards or protection against racist abuse)
Internship/residency	Individuals are finally referred to as 'Dr.' after securing a medical license by passing step exams and by physician-run medical boards approving their applications; assigned titles reveal value/identity depending on usefulness to medical team, rung on the professional ladder and amount of power (people referred to and valued according to 'PGY', 'intern', 'resident', 'fellow', 'attending' or 'student' titles, not first name; no similar regard for humanity or social identities	Obedience to hierarchy; sacrificing holidays and family events, delaying marriage and family, due to clinical rotations and related demands; enduring and overlooking racist and other discriminatory behaviour by superiors, due to fear of not being allowed to complete residency training	'Paternalism' (those holding power, like doctors, assume they are qualified and entitled to define standards and make decisions for those without power, like patients; this paternalism also operates within clinical teams where more senior physicians hold power over residents and students and can dictate whether they can leave the hospital); 'individualism' (isolation and loneliness stemming from working so much, leading to depression)

Grooming and reinforcement strategies work in tandem to assimilate students and residents into medical culture and its related whiteness, white supremacy and white supremacy culture. Success and survival require socialisation into the profession through its hidden curriculum, which is closely intertwined with white supremacy culture.

school identity to embody an idealised identity imposed by medicine's dominant white supremacy culture (Berry 2015). The so-called 'imposter syndrome' that most medical students experience may more accurately reflect the distress stemming from changing identity, repressing personal values and striving for unattainable perfection as part of this assimilation (Martinek 2021; Rosenthal *et al*. 2021). During residency, 80-hour work weeks, sacrificing time with family and for non-professional interests, and pledging allegiance to the profession prove costly. Depression rates soar to 29%, leaving many questioning whether to stay in medicine. The crisis of physician suicide, afflicting 300–400 physicians each year, may signal the unnamed devastation wrought by this trauma (Legha 2012).

UNGASLIGHTING THE PHYSICIAN BURNOUT DISCOURSE

The physician burnout discourse is a form of gaslighting because it obscures the psychological and emotional distress stemming from this assimilation trauma (Davis and Ernst 2021; West *et al*. 2016). Burnout's related well-being narratives centering resilience, professional fulfilment, and interventions like mindfulness and reduced workloads seem innocuous. But they damage by distracting from the systems of oppression exerting harm, scapegoating individuals suffering under their weight and deleting the history giving rise to them (West *et al*. 2016). Ultimately, burnout serves as a 'rigged discourse', maintaining the ruling elite's power while providing system justification to defend the medical profession as good, fair and legitimate—not white supremacist—and to preserve 'business as usual' (Giridharadas 2019; Jost 2020). Notably, leaders of the physician burnout movement, like West and Shanafelt, are beneficiaries of the white cisheteropatriarchy with a personal and professional stake in maintaining it by ensuring it remains unnamed (West *et al*. 2016; West, Dyrbye, and Shanafelt 2018; Shanafelt 2021).

Ungaslighting the physician burnout discourse is a multifaceted strategy. Resisting assimilation involves individual self-preservation strategies, like (1) inventorying values, principles and interests to anchor individuals to a more human identity outside the profession; (2) protecting this pre-medical core identity by compartmentalising the professional identity developed to survive institutional contexts; and (3) cultivating reflective practices with peer facilitators to expose power dynamics fuelling systems of oppression during clinical and educational encounters (Lijadi 2018; Bettencourt 2021; Hare 2007). Equally important is recognising how commonplace, celebrated aspects of training, like the white coat ceremony and never-ending shelf, step and board exams, perpetrate harm. Functioning as grooming and reinforcement strategies indoctrinating individuals into the profession, they require mastering various white supremacy culture characteristics that ultimately disconnect us from each other and ourselves, leaving us spiritually broken (table 1).

Bold and radical frameworks inspire further efforts to ungaslight the burnout discourse. Abolition calls for a restructured society that eliminates punishment and harm as solutions to everyday problems (Campbell 2009; Kaba and Murakawa 2021). It inspires a collective movement to end, not reform, the upstream systemic sources enabling downstream violence, like abuse and exploitation during training (Iwai, Khan, and DasGupta 2020). Decolonisation decentrers the dominant, white, heteronormative, patriarchal gender binary narrative and rejects Eurocentric 'evidence-based' practices and ways of knowing that promote scientific racism (Li 2020; Dimant *et al*. 2019). Critical race theory illuminates white supremacy's ubiquity and calls for activism to dismantle the intersecting forms of oppression emanating from it (Ford and Airhihenbuwa 2010). These frameworks guide us towards rejecting reformist physician well-being 2.0 discourses that negate structural sources of harm, like racism and whiteness, as well as their deep historical roots (Shanafelt 2021). They expose physician burnout, professionalism and resiliency as mainstream narratives sanctioning marginalised doctors, medical students, nurses and other allied health professionals' ongoing abuse (Bae *et al*. 2019; Shah *et al*. 2021). Furthermore, these frameworks promote the introspection and deep historical reckoning required to transform the trauma of medical training into a healing experience that rejects white supremacy culture.

Antithetical to the white cisheteropatriarchal invincibility seeded centuries ago, these changes mandate a redo, rather than a revision, to develop a transparent, rather than a hidden, curriculum that safeguards against oppression. Reimagined medical curricula grounded in these bold and radical frameworks would reveal the historical arcs of oppression giving rise to the medical profession's identity rooted in whiteness (Asmerom *et al*. 2022; Legha, Richards, and Kataoka 2021). They would guide the next generation of doctors to dismantle its white supremacy culture by teaching them to do the following: interrogate deficit-based practices pathologising human experience; privilege relational-centred practices to promote healing; share power with patients to leverage medical expertise with their experiential knowledge; preserve the humanity of trainees and patients by resisting grooming and reinforcement strategies (table 1) (Gómez *et al*. 2016). Senior medical personnel would be mandated to reject the hidden curriculum and to adopt a reflective supervision model epitomising the characteristics most antithetical to white supremacy culture, like humility and critical consciousness. Doctors who have fled the system to heal and transcend their medical identity and who have committed to de-assimilating and liberating themselves from white supremacy culture are poised to lead the charge. Their first task, overhauling medical education curricula, generating institutional guidelines to dismantle whiteness, and leading accreditation bodies monitoring and evaluation of reimagined training and practice activities in medical schools nationally. These efforts can help envision the 2022 Flexner Report needed to acknowledge the harm accumulated over the past 110 years, prevent assimilation trauma by shutting down medical schools that fail to facilitate necessary changes and reimagine a new American medicine that advances collective healing for the future.

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