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

Rupinder K Legha,[1] Nathalie N Martinek[2]

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).

[1]Los Angeles, California, USA
[2]Melbourne, Victoria, Australia

Correspondence to Dr Rupinder K Legha, Rupinder K Legha MD PC, Los Angeles, CA 90056, USA; antiracistmd@gmail.com

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.

Twitter Rupinder K Legha @RupiLegha

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Supplemental Table 1. Key Definitions

-Ableism: Ableism is a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical, and therefore essential and fully human (Campbell 2009). In medicine, ableism informs notions of who is “normal” and well and who is abnormal and sick, patients and providers alike. During medical training it involves pathologizing and devaluing students and trainees who do not fit the profession’s white cisheteropatriarchal ideal or embody its **white supremacy culture** characteristics.

-Abolition and **abolition medicine:** Abolition seeks to undo the ways of thinking and doing things that see prison and punishment as solutions for social, economic, political, behavioral, and interpersonal problems. It calls for defunding the police and rejects reform, demanding reimagination to achieve transformation (Kaba and Murakawa 2021). **Abolition medicine** involves constructing new systems of community-based care that challenge the medical-industrial complex rooted in slavery to build a new, healthier, more just society committed to healing. It reimagines the work of medicine as an antiracist practice and demands historical redress, such as desegregating the profession, and reparations for communities devastated by medical experimentation (Iwai, Khan and Gupta 2020).

-**Acculturation**, **assimilation,** and **assimilation trauma**: Assimilation is the process whereby individuals or groups of differing backgrounds or social identities are absorbed into the dominant culture of a society or profession. Assimilation is the most extreme form of acculturation. Throughout history, racial, sexual, gender and other minority groups have been forced to assimilate into **whiteness** in order to survive. Assimilation trauma refers to the **trauma** (defined below) that individuals experience as a result (Berry 2015). In medicine, assimilating into medical culture involves taking on the traits of the dominant **white supremacy culture** while suppressing devalued traits to such a degree that assimilating students and residents becomes socially indistinguishable from other senior physicians.The related loss of self constitutes a trauma.

-Cissexism: Cissexism is an ideological system that denies, denigrates, and stigmatizes any noncisgender form of behavior, identity, relationship, or behavior and can operate in a similar manner as heterosexism (Dimant et al. 2019). In medicine, cissexism is manifested through cisnormativity in medical education, the biologization of gender in clinical care, and the discrimination gender nonconforming students and patients experience as a result.

-Critical Consciousness: Critical consciousness is a term pertinent to **Critical race theory** (defined below). It signifies digging beneath the surface of information to develop deeper understandings of concepts, relationships, and personal biases. In medicine, cultivating critical consciousness implies rejecting its **hidden curriculum** and **white supremacy culture** by actively questioning knowledge and power dynamics, instead of quietly complying with the medical hierarchy and the profession’s emphasis on an indisputable scientific expertise (Ford and Airhihenbuwa 2010).

-Critical Race Theory (CRT): CRT is a theoretical framework providing a critical analysis of race and racism to combat root causes of structural racism, highlighting the relationship between race, racism, and power. Key concepts: *Ordinariness* (racism and white supremacy in post-civil rights society are integral and normal rather than aberrational);

Centering in the margins (shifting discourses' starting point from the majority group's perspective--e.g. whiteness--to that of marginalized groups);
Intersectionality (the multidimensionality of oppressions--race, gender identity, class, national origin, sexual orientation--resulting in disempowerment); *Activism:* (commitment to social justice, scholars assume an active role in "eliminating racial oppression as a broad goal of ending all forms of oppression"; and *Critical consciousness* (digging beneath the surface to develop deeper understandings of concepts, relationships, and personal biases) (Ford and Airhihenbuwa 2010). In medicine and public health, CRT recognizes that eliminating racism and white supremacy is crucial for health equity. It emphasizes that race, including **whiteness**, is a social, not a biological, construct.

-Culture: Culture is a set of shared values, attitudes, goals, practices and learned behaviours found within a group, community, town, state, or a nation. These behaviours are acquired through socialisation from family, social groups, education, and social organisations (Berry 2015). Medical culture is characterized by a fixation on perfectionism and self-sacrifice among doctors, scientific expertise, and claims to objectivity. These notions obscure medicine's legacy of **white supremacy** and myriad **white supremacy culture** characteristics.

-Decolonization: Decolonization is the process of revealing and dismantling institutional and cultural forces and practices away from the dominant white, heteronormative, patriarchal, and gender-binary narrative. It strives to dismantle harmful practices that derive from and reinforce systemic privilege and **whiteness**. It recognizes the heavily Eurocentric approaches that are colonizing. It advances a movement to seek justice and liberation through education, collective care, and activism. It centers the needs of racially minoritized people and the LGBTQIA2S+ community, as well as people with disabilities (Li 2020). In medicine, decolonization involves interrogating and dismantling the ways in which **whiteness** has been normalized by eugenics, scientific racism, and medical training's **assimilation trauma**.

-Experiential knowledge: Experiential knowledge is a term that relates to **CRT** (defined above). It signifies ways of knowing that result from critical analysis of one's personal experiences. In medicine, valuing patients' experiential knowledge and lived experiences challenges the assimilation trauma of medical training by resisting its emphasis on scientific expertise. It also humanizes clinical practice by centering the perspectives of patients, rather than physicians (Ford and Airhihenbuwa 2010).

-Gaslighting: Gaslighting is an insidious psychological manipulation by a person or group in power feeding victims false information, leading them to question themselves and their reality, growing more complex and potent over time, making it increasingly difficult for victims to see the truth (Davis and Ernst 2019). In medicine, gaslighting involves more senior physicians' eroding students' and trainees' confidence to the point where they question their competence and validity as physicians. It also involves the profession positing theoretical frameworks (like "burnout") that uphold the profession's image as inherently good while obscuring its toxic practices and oppressive history.

-Grooming: Grooming refers to the methods used by a person in a position of power to gradually build a relationship, trust, and emotional connection with another so they can manipulate, exploit and/or abuse them. The term is often used to describe the process

leading to sexual abuse and can broadly be applied to workplace/professional relationships (Lanning 2018). In medicine, grooming transpires when senior physicians capitalize on the profession's toxic power dynamics to engender trust from students and trainees, who are reliant upon them for career advancement, only to exploit their work and contributions later.

-Hidden curriculum: The term hidden curriculum is unique to medicine. It refers to medical education as more than simple transmission of knowledge and skills; it is also a socialization process. Wittingly or unwittingly, norms and values transmitted to future physicians often undermine the formal messages of the declared curriculum. The hidden curriculum consists of what is implicitly taught by example day to day through personal interactions and institutional practices and policies, not the explicit teaching of lectures, grand rounds, and seminars (Mahood 2011).

-Imposter syndrome: Imposter syndrome is a phenomenon of doubting one's skills, talents, competence, and accomplishments with fear of being exposed as a fraud (Martinek 2021; Rosenthal et al. 2021). In medicine, imposter syndrome is a symptom of **assimilation** into the **white supremacy culture** ideal and is almost the norm among medical students, due to the profession's unrealistic expectations for perfection and its never-ending tests, evaluation, and measurement of competency.

-Intersectionality: As it relates to white supremacy, intersectionality captures how the powerful elite have constructed white supremacy for centuries to intersect with, support, reinforce, and reproduce capitalism, class oppression, gender oppression, heterosexism, ableism, classism, and many other systems of oppression that, in turn, reinforce and reproduce white supremacy (Crenshaw 1990). In medicine, intersectionality helps conceptualize the layers of harm some students and trainees experience as a result of being marginalized by medicine's multiple forms of oppression (captured by the term **white cisheteropatriarchy**).

-**Marginalization**: Marginalization is the process in which groups of people are excluded by the wider society. Marginalization is often used in an economic or political sense to refer to the rendering of an individual, an ethnic or national group, or a nation-state powerless by a more powerful individual. In general, marginalizing refers to the process of relegating, downgrading, or excluding people from the benefits of society (Crenshaw 1990). In medicine, white cisheterosexual men are overwhelmingly entitled to leadership positions, despite maintaining racist beliefs and practices, while racially minoritized people are marginalized by the overwhelming obstacles they face to become and advance professionally as doctors.

-**Oppression:** Oppression is a combination of prejudice and institutional power that creates a system that regularly and severely discriminates against some groups in order to benefit other groups. It is also defined by the unjust or cruel exercise of authority or power especially by the imposition of burdens; the condition of being weighed down; an act of pressing down; a sense of heaviness or obstruction in the body/mind (National Museum of African and American History & Culture 2019). In medicine, multiple educational practices are oppressive, resulting in the assimilation trauma of medical training.

-Power and hierarchy: Power is the ability to influence others. One of the ways power operates is through the establishment and operationalization of hierarchies, an organizational form that stratifies people or groups based on their possession of social

resources. In medicine, the clinical environment is intensely hierarchical, and clinical work and learning are contingent on interaction, which makes consideration of hierarchy and power directly relevant to medical education (Vanstone and Grierson 2022).

-Professionalism: Professionalism is the competencies, skills, and expertise professionals are expected to attain. In medicine, professionalism refers to the "attitudes and behaviors that serve to maintain patient interest above physician self-interest." However, it serves as a **rigged discourse** (see definition below) by supposedly advancing patient interest while actually promoting **assimilation** to **whiteness** and other racist practices that disproportionately harm racially minoritized students and trainees (Sethuraman 2006).

-Racism: Racism is a white supremacist system of advantage and **oppression** based on race. It involves one group having the power to carry out systematic discrimination through institutional policies and practices and by shaping the cultural beliefs and values that support those racist policies and practices. Racism and white supremacy culture are therefore closely related and mutually reinforcing (Tatum 2014). In medicine, racism's role in shaping knowledge, clinical practice, and professional identity–though widespread–have largely been obscured by the profession's predominant **white cisheteropatriarchy**.

-"Rigged discourse": The concept of a rigged discourse is described in journalist Anand Giridharadas' book *Winners Take All: The Elite Charade of Changing the World*. It speaks to the way in which elites and the powerful use the conquest of language, of culture and of our common sense to cement their role and social position. He provides the example of "resilience," "a concept that sounds great but that is actually just about adjusting to societal crappiness rather than fixing it" (Giridharadas 2019). In medicine, physician burnout is an example of a rigged discourse that upholds the profession as noble while obscuring its oppressive history and toxic practices.

-System of oppression: The term "system of oppression" calls attention to the historical and organized patterns of mistreatment. In the US, systems of oppression (like systemic **racism**) are woven into the very foundation of American culture, society, and laws. Other examples are sexism, heterosexism, **ableism**, classism, ageism, and anti-Semitism (National Museum of African and American History & Culture 2019). Medicine's interlocking systems of oppression–its **white cisheteropatriarchy**–reinforce the oppression of marginalized social groups while elevating dominant social groups, a phenomenon reflected in the profession's overwhelmingly white male leadership and the discrimination racially minoritized students endure during training.

-**System justification:** System justification theory refers to a motivational tendency to defend or rationalize the existing system as good, fair, and legitimate; preserving "business as usual," despite the harm caused. According to system justification theory, people are motivated (to varying degrees depending upon situational and dispositional factors) to defend, bolster, and justify prevailing social, economic, and political arrangements (i.e., the status quo) (Jost 2020). In medicine, the burnout discourse serves as a form of system justification that preserves the profession's white hegemony while obscuring its toxic practices, such as the trauma of assimilating to whiteness during medical training.

-Trauma: Trauma is any experience that overwhelms the nervous system such that the person is unable to release or process the stressful event, and is characterized by emotional dysregulation, dissociation, and relational disconnection. Traumatic experiences

also damage the person's sense of self by shattering the beliefs, morals, philosophies, and ethics that gave their life meaning and defined their worldview (known as shattered assumptions theory). Medical training constitutes a trauma because it involves assimilation to whiteness and a resulting betrayal of trust in self (Gómez et al.2016; Cromer et al. 2018).

- White cisheteropatriarchy: White cisheteropatriarchy involves the deep interconnection between multiple systems of oppression related to whiteness, cissexism, heterosexism, and patriarchy–which itself is defined as the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over girls, women, and gender nonconforming people in society in general (Hooks 2010). In medicine, it refers to a system of power based on the dominance and assumed supremacy of cisgender heterosexual white men through the exploitation and **oppression** of all others.

-Whiteness: Whiteness refers to the way that white people, their customs, culture, and beliefs operate as the standard by which all other groups are compared. Whiteness and the normalization of white racial identity throughout America's history have created a culture where racially minoritized people are seen as inferior or abnormal (National Museum of African and American History & Culture 2019). In medicine, whiteness permeates myriad domains of the profession, notably through white supremacy culture's stronghold on medical training and professional culture.

-White supremacy: White supremacy refers to the ways in which the ruling class elite or the power elite in the colonies of what was to become the United States used the pseudo-scientific concept of race to create whiteness and a hierarchy of racialized value in order to disconnect and divide white people from racially minoritized people and to disconnect and divide racially minoritized people from each other (Okun 2021). In medicine, white supremacy has shaped the profession since its inception, defining who is fully human (white people) and who is not (racially minoritized people)--whether they are patients or doctors. White supremacy has given rise to eugenics, scientific racism, and forced experimentation, all of which have terrorized racially minoritized people while enforcing the racial dominance of whites and attempts to erase representations of imperfection while promoting homogeneity.

-White supremacy culture: White supremacy culture is the widespread ideology baked into the beliefs, values, norms, and standards of groups, communities, and institutions and teaching both overtly and covertly that whiteness holds value. Core characteristics of medicine's white supremacy culture include perfectionism, individualism, paternalism, belief in one right way, and worship of the written word. (Okun 2021). **Assimilation** to white supremacy culture during training results in physicians' silencing, numbing, and disconnecting from their basic humanity and marginalized social identities in service of a false safety based on the idea that whiteness and its related white supremacy culture are both better and normal.

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