

Racial Trauma Perpetuated by Academic Medicine to Those in Its Ranks

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Within medicine, as underrepresented minorities (URMs) we share a common experience of being systematically excluded at every step of our academic medicine journey: from medical education to training and clinical practice in academic medical settings, to research and medical publishing. Although the experiences faced by Black and Brown individuals in this country are not monolithic, throughout our training we experience a full spectrum of prejudice and discrimination from microaggressions that slyly question our competence to outright explicit racism in the form of harassment or “jokes” from members of a community from those who are supposed to serve as our colleagues and mentors.

During Recruitment and Training

These experiences begin before we decide to join the medical field. We often hail from backgrounds where the long-lasting effects of structural racism color our daily experiences. Our neighborhoods, cities, and countries are underfunded and under-resourced, with high rates of poverty, lack of access to health care, repeated trauma of interpersonal violence, and police brutality. We are subjected to cost-prohibitive matriculation requirements that primarily benefit those who grew up with privilege: costly entrance exams with equally costly prep materials, shadowing experience requirements, and mentor availability. The data are clear: race and socioeconomic status still represent strong predictors of who gets into medical school.¹ While many of our counterparts have the privilege of financial support from their families, URM applicants are disproportionately likely to be financially supporting relatives even in medical

school. Despite overcoming these challenges, we constantly hear debates about the erroneous notion that some of us—do they mean me? — “got in because we are a minority.”

We are subjected to trauma during our recruitment. As we advance, we are asked to write personal statements and re-tell our traumas as examples of our resiliency. Not too long ago, an interviewer asked one of us, “What makes you different?” I told my story, and the interviewer cried. Yes, it was hard for this interviewer to hear the story—but consider the cost of being asked to relive my trauma to prove my worth. Far too commonly, we share our lived experiences to have our listeners center themselves as they deal with their emotions rather than committing to change the environment that continues to traumatize us. We share these stories because there is an expectation that we will. Even when we attempt to discuss other subjects, interviewers’ probe until they find the stories they are looking for. Our personal journeys become entertainment to be discussed behind closed doors.

While Doing Our Work

Once recruited into the medical field, we often find ourselves tokens for diversity, equity, and inclusion—called upon for photo-ops and then quickly shuffled to the back once the cameras are away. Our institutions boldly claim efforts to diversify medicine and fight systemic racism while continuing to propagate the culture of White Supremacist values that institutional racism is built upon. They make their anti-racist claims even as they continue blatant mistreatment and abuse of URM trainees and staff. Those same trainees and staff find themselves exhausted from the demands of their practices but also from the added weight of systemic racism and

intrapersonal racism reflected in their workplace. In clinical settings, minority providers see the daily effect of health disparities that ravage communities of color. From the medical equipment to the tests, to the system is repeatedly inflicting harm upon minority populations that it reportedly promises to serve.²

URM trainees and faculty do the heavy lifting of anti-racism work without recognition, often without compensated effort, or even more rarely with a true commitment to substantive correction of the problems we identify. We are met with insincere promises of change but then confronted with the bitter truth of either an unfulfilling “compromise” that serves as a bandaid, or we are eventually labeled “trouble-makers” and pushed out of our institutions. This collective phenomenon, of URM faculty and trainees doing the disparity-related work for has been termed “minority tax”.³ URM faculty and trainees persist while not only sacrificing their advancement in academics but their mental health and wellbeing because of a commitment to our patients and our profession—but for who is forcing this trade-off useful?

There are extreme examples of such behavior even in medical education: Drs Dennar and Khoury. Dr Princess Dennar, former medicine-pediatrics residency director at Tulane University, was ousted from her position as retaliation after spending years speaking up against racial discrimination at her workplace.⁴ Dr. Aysha Khoury was asked to lead a session related to racism for a medical school class at Kaiser Permanente – Bernard J. Tyson School of Medicine in response to recent racial violence. She included her experience as a Black woman; she was then fired from her teaching position with little explanation. Dr. Khoury was asked to tell her story of

experiencing injustice, and the resultant vulnerability used against her when it made those who asked uncomfortable.⁵

The impact of intersectionality on women of color creates a unique vulnerability in our experiences as we are not only subject to the harassment from a racial/ethnic avenue but also from gendered one. Many women doctors express frustration about being mistaken for nurses despite proper identification, but even more frequently URM women doctors find themselves mistaken for kitchen or janitorial staff. This additional layer of minority identity often leaves women even further behind their male counterparts in promotions and advancement while simultaneously leaving them at risk of swift and punitive retribution when they speak up—as in the cases of Drs. Dennar and Khoury.

The data are clear—these are not isolated incidents. Surveys of Black, Latinx and Native American residents showed that we suffer from additional unnecessary burdens secondary to our race and/or ethnicity.⁶ These microaggressions—which honestly are just repeated racial insults that aren't considered significant enough to be considered overt racism—are unsurprisingly associated with poorer mental health and quality of life amongst people of color.⁷ We face challenges that are rarely recognized and acknowledged by our supervisors and frequently not taken into account during performance evaluations or as previously stated weaponized against us in carefully crafted feedback.⁸

In Research and Publishing

In research, there are significant disparities in NIH funding that directly affect Black investigators as they are more likely to be pursuing disparities intervention research. This lack of funding leads to their publications often being less cited and usually published in lower impact journals.⁹ Work by Dr. Boyd and colleagues demonstrates that in the past 30 years there have been over 200,000 articles published in the top American and British journals and less than 1% include the word racism, and over 90% of those were opinion pieces.¹⁰ This lack of funding and support is a testament to the power medical institutions and journals have in their ability to allow systemic racism to continue to influence our current practice paradigms.

Recently, two of the most prominent American medical journals (*JAMA* and the *New England Journal of Medicine*) released a podcast and a letter-to-the-editor that, in summary, questioned the existence of systemic racism.^{11,12} As academicians, we understand that the free flow of ideas exists at the core of science. Every thesis has an anti-thesis, and it is through observation and debate that theories and hypothesis are tested and then become widely accepted. Yet leading medical journals set of the terms of state-of-the-art debate. We think the questioning of the existence of systematic racism represents a failure of best-current-thinking and is affirmatively harmful. Not every idea nor every question is worthy of widespread discussion—most submissions to *JAMA* and *NEJM* are not given prominence, because they represent bad logic from bad facts arranged in disproven arguments.

There are two ways in which re-airing out-of-date questioning of the existence of structural racism causes harm. The first is its impact on us—URM clinicians and scientists in the

community. Medicine, as we have argued, reinforces our traumas and then denies that trauma's existence. Having to deal with the trauma that this country perpetuates on Black and Brown bodies and also experience racial trauma at work, has an effect in our academic productivity and ability to contribute. Most of us, given the institutional isolation we face as minorities, suffer alone. We have to put aside our internal struggles and carry on in an unforgiving environment. Our stories are used as promotion for our institutions and/or consumption to check a box for allyship. But when we come forward to ask for change, our experiences are quickly dismissed, and we often face punitive retribution that is harmful to our careers and wellbeing.

The second is the poisonous legitimacy that prestigious medical platforms provide to these ideas outside of medicine. Consider, by analogy, the decision to publish in *The Lancet* a small study of twelve patients by Dr. Wakefield and colleagues purporting to show a linkage between autism and vaccination.¹³ They were just asking questions. Decades later, there is perhaps no more thoroughly debunked study within medicine. Yet the fact that this study was published remains a beacon of its legitimacy in the anti-vax movement—and continues to cost lives to this day. If editors at major medical journals believe the evidence for structural racism on health is inconclusive—and are unwillingly to have thoughtful, truthful and nuanced discussions about structural racism in healthcare—then why should medical centers, clinicians, and health policy lobbyists from making concerted efforts to push for real substantial change?

Do Better

We—your Black, LatinX, Indigenous, and other historically underrepresented colleagues, mentors, trainees, friends—continue to long for a medical community that sees our trauma, acknowledges it, and fights for future generations to not experience it. Currently, academic medicine continues to benefit from our struggle, yet creates a hostile environment, and then publicly denies the existence of structural racism. This hurts all of us, including the patients we work so hard to take care of. It invalidates our struggle, gives power to the already powerful, and continues to segregate us. It is time we stop hiding in our ivory towers and truly begin to advocate for an academic community that is inclusive and supportive of its colleagues and patients.

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