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"Changing the narrative": a study on professional identity formation among Black/African American physicians in the U.S.

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Abstract

Professional identity formation (PIF) is considered a key process in physician development. However, early PIF research may have inadvertently left out experiences from ethnically/racially minoritized physicians. As a result, the PIF literature may have forwarded dominant perspectives and assumptions about PIF that does not reflect those of minoritized physicians. This study used a cross-sectional study design, in which interview data was initially collected using constructivist grounded theory and then analyzed using critical lenses. Participants included 14 Black/African American students, 10 residents, and 17 attending physicians at two Southern medical schools in the U.S. Coding included the *both/and* conceptual framework developed out of Black feminist scholarship, and further analyzed using medicine's culture of Whiteness. These lenses identified assumptions made in the dominant PIF literature and how they compared to the experiences described by Black physicians. The results show that medical education's historical exclusion of minoritized physicians in medical education afforded a culture of Whiteness to proliferate, an influence that continues to frame the PIF research. Black physicians described their professional identity in terms of being in service to their racial/ethnic community, and the interconnectedness between personal/professional identities and context. Their professional identity was used to challenge larger social, historical, and cultural mistreatment of Black Americans, findings not described in the dominant PIF research. Black physicians' experiences as minoritized individuals within a culture of Whiteness reveals that the PIF literature is limited, and the current framings of PIF may be inadequate to study minoritized physicians.

Keywords Professional identity formation · Socialization · Minoritized physician · Whiteness · Euro-centric perspective · UiM · Post-colonial theory

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Introduction

Professional identity formation (PIF) is a key process in the development of physicians, and as such, much of the PIF research concentrates on how trainees internalize the beliefs, values, and behaviors of the profession (Cruess et al. 2015; Jarvis-Sellinger et al. 2012). To date, the majority of the PIF research has been fairly granular, focused on the social and cognitive processes influencing one's professional identity. However, several studies conducted in cross-cultural settings have begun to widen their methodological and theoretical lenses and revealed that the dominant PIF research is steeped in Euro-centric and Western perspectives (Al-Rumayyan et al. 2017; Cruess et al. 2010; Helmich et al. 2017). These terms, Euro-centric/Western perspectives are often used interchangeably, and refer to the tendency of Western societies (i.e. United States) to interpret the histories, cultures, and experiences of non-Europeans through lenses that reflect dominant society, and not those who are oppressed, marginalized, or socially unequal (Said 1985; Fanon 1952). Viewing marginalized communities through these lenses is problematic because it silences the authentic experiences of minoritized individuals, and maintains their subjugation and limited social representation in society (Said 1985).

Such examples of emerging PIF work include that of Helmich et al. (2017) who demonstrated that Dutch participants differ from Taiwanese participants in their conceptualization of what it means to be a doctor. Where it was previously thought there was a universal understanding of the profession, they found that this definition is highly influenced by culture and context. Others, such as Al-Rumayyan et al. (2017) found that there is no single framework on professionalism that can be globally acknowledged. Rather, geographical regions conceptualize professionalism in ways that support their unique values and commitments within the profession. These two studies echo previous findings from Cruess et al. (2010) who argue that there is no universal social contract between physicians and society. Rather, the only shared sense of responsibility physicians have is to engage in healing; all other forms are influenced by the unique socio-historical and cultural contexts of various geographical regions. These studies challenge Euro-centric/Western conceptualization of professionalism and PIF, and demonstrate that culture and context are highly influential in shaping one's professional identity.

In addition to culture and context, there is reason to believe race/ethnicity must be given greater consideration in PIF research, especially within the U.S. Many researchers assume sociocultural variables, such as race, ethnicity, class, and gender are unrelated to medical training (Beagan 2000, 2001, 2003, 2005), an assumption has been traced to early PIF writings published in the 1950s–1960s (Becker et al. 1961; Merton et al. 1957). This early research was conducted by White researchers studying White male physicians at a time when medical education in the U.S. was 97% White and 91% men (Olsen 2019). As a result, race and ethnic data is typically omitted in PIF research, evidenced by recent work from Volpe et al. (2019) who found only a small fraction of the PIF literature meaningfully examined trainees' socio-cultural data (e.g. race, ethnicity, gender, etc.) as part of the studies' analysis and interpretation.

The need to include race/ethnicity in PIF research is critical in the study of physicians considered underrepresented in medicine (UiM), a term coined by the American Association for Medical Colleges (AAMC) for those physicians who are part of a racial and ethnic population that is underrepresented in the medical profession relative to their numbers in the general population (American Association of Medical Colleges 2004). These physicians experience what is known as "leaky pipelines," multiple points where

potential physicians dropout of their educational programs before they are have a career in medicine (Freeman et al. 2016). They also face a myriad of challenges related to promotion and tenure in academic medicine (Osseo-Asare et al. 2018) once they are trained as physicians. However, Black/African American physicians have other historical reasons for why they remain under-represented in medicine.

For nearly a century, Blacks/African Americans were excluded from medical education as a result of the Flexner report (Wright-Mendoza 2019; Steinecke and Terrell 2010), a document that is often heralded as an important turning point in U.S. medical education, but also responsible for the closing of more than 75% of U.S. medical schools for being inadequately staffed and supplied (Flexner et al. 1910). The Flexner report was instrumental in standardizing medical education in North America, but was devastating for the training of Black/African American physicians (Savitt 2006). Unlike Whites who could enroll elsewhere, Blacks/African Americans were not accepted in White medical schools and were left without options for pursuing a career in medicine. As a result, for nearly a century Americans only saw White doctors represented in the medical profession, an absence that has influenced Americans' perception of what a doctor looks like (Frost 2019).

Although this study initially set out to understand the PIF experiences of Black/African American physicians at different points in their career, it quickly became evident that their experiences did not fit aspects of the dominant perspectives forwarded in the PIF literature (Cruess et al. 2015). Rather, these physicians described their professional identity in ways that differed from those appearing in the literature base, and invoked the interconnectedness between personal and professional identities and context (Tsouroufli et al. 2011; Rees and Monrouxe 2018).

Therefore, in a departure from previous PIF research, this study uses a critical lens to gain new perspective on the topic of PIF. To do so, we employed post-colonial theory, a theoretical approach that is concerned with the aftermath of Western colonialism in organizations and how it continues to effect individuals (Ashcroft et al. 1995). Post-colonial theory is a tool to challenge dominant Euro-centric/Western perspectives that have come to be seen as the norm in American society, and supports perspectives that have been silenced or ignored because they don't reflect this norm (Scheurich and Young 1997; Stanfield 1985).

Additionally, we used a critical lens because the U.S. has a unique sociopolitical history. Technically, the U.S. is not considered a post-colonial society. Early European settlers tried enslaving Native Americans and creating a system of indentured servants, these efforts were abandoned in favor of transporting Africans to work as slaves (Morgan 1975), thus thwarting the U.S.'s status as a post-colonial society. Additionally, studying Blacks/African Americans' experiences through "settler colonialism" isn't appropriate because this community is not indigenous to the U.S. and this framing is reserved for Native peoples (Snelgrove et al. 2014; Veracini 2011). Without a clearly defined sociopolitical status that takes into consideration the U.S.'s historical relationship with Blacks/African Americans, we chose to frame the U.S. as a post-colonial context because this community shares many of the same sociopolitical challenges present in other post-colonial societies.

Therefore, using post-colonial theory, we analyzed Black/African American physicians' PIF experiences at different points in their career to understand their unique PIF experiences. Rather than forwarding the dominant conceptualizations in the PIF literature, this study takes into account their multiple layers of oppression (Collins 1989) that include being a minoritized individual within society and their chosen profession. The goal of this study is to challenge the assumptions made in the dominant PIF literature to develop a new understandings of PIF specific to Black/African American physicians.

Methods

This study took a cross sectional approach to understand the PIF experiences of Black/African American students, residents, and attending physicians at two Southern medical schools. Cross-sectional studies rely on data collection and analysis from multiple participant groups at one time point to better conceptualize a topic of interest and understand a burden within a specific population (Strauss and Corbin 1998). Cross-sectional studies are an ideal design when longitudinal studies on a specific topic are needed, yet the data collected is thought to be time-sensitive or immediately relevant to the field. This approach does not preclude the possibility of researchers continuing to engage with participants in longitudinal research, rather cross-sectional studies provide a means to share important findings with the research community while more data is being collected (Campbell and Rodriguez 2018; Rodriguez et al. 2014; Campbell and Rodriguez 2019). In the present case, the researchers felt it was important for UiM physicians' experiences to be voiced in medical education sooner than later to shape the community's conversations about PIF for UiM physicians.

The researchers consider themselves constructivists embracing the idea that the world is socially constructed and all participants are historical and social subjects influenced by spatial and temporal settings that have shaped their constructions (Charmaz 2008). Furthermore, one of the lead researchers is a critical constructivist and is concerned with how knowledge becomes inscribed with particular values and forwarded through research and pedagogical practice (Kinloe 2008). These values are almost always reflective of the socially powerful, therefore critical constructivists raise questions about how knowledge is reproduced in society, whose interests it serves, and how it shapes the identities of those who internalize the work. In this study, we took a critical constructivist approach by calling into question the assumptions made in the dominant PIF research and the ways in which it marginalizes the experiences of UiM physicians.

Participants included 14 Black/African-American students, 10 residents, and 17 attending physicians who were recruited using the snowball method originating from a combination of researchers' and participants' personal/professional networks at the Medical College of Georgia (MCG) and Emory University. Initial recruitment included personal emails and presentations in various clinical and classroom settings. Semi-structured interviews were conducted with each participant, exploring moments when they perceived their race/ethnicity as salient in their profession. Probing was used to assess participants' reactions to these moments and how they intersected with their professional identity, which we defined as thinking, feeling, and acting like a physician (Miller 1990).

Interviews were conducted by TW and NW and lasted approximately 45–60 min. Data collection and analysis for the overall study were conducted using a constructivist grounded theory approach to ensure lines of inquiry were thoroughly followed-up throughout the research process (Kennedy and Lingard 2006) For example, after each interview, TW and NW discussed its contents, including new findings with potential relevance. These ideas were then taken back to the full research team for discussion and focused on understanding how the individual interview fit within the larger data set. Subsequent interviews included probing questions that asked participants about these new findings. This iterative process ensured any new lines of inquiry were explored and notified the research team when data saturation was reached. The final interview questions were published in a concentrated analysis of UiM medical students' PIF (Wyatt et al. 2020).

The current study, includes interview data from all students, residents, and physicians, which was coded using the *both/and* conceptual framework developed out of Black feminist scholarship (Collins 1986), a framework that recognizes the interlocking nature of oppression among minoritized groups and the need for research paradigms that are developed out of these experiences. This framework identified when participants described their professional identity as Black physicians (*both* Black and a physician) and when they described their identity in ways that included, yet extended beyond being a Black physician. This analysis helped to understand how participants conceptualized themselves and their identity as UiM physicians.

Coding with the *both/and* framework also revealed that participants' professional identities were shaped by the culture of medicine. We then analyzed the codes through post-colonial theory (Dei and Asgharzadeh 2001; Fanon 1952; Spivak 1988), namely that organizations are cultural artifacts that reflect the dominant society's goals, values, and beliefs via an invisible culture of Whiteness (Evans and Moore 2015). Whiteness is a location of structural advantage and a set of cultural practices that go unmarked and unnamed, and has proliferated as a result of Euro-centric/Western perspectives (Frankenberg 1993). Whiteness prospers in organizations (Ray 2019) through social and material resources (Hafferty 1998), and is seen as a form of day-to-day oppression (Moane 2003). Interpreting participants' PIF experiences within the culture of Whiteness was a decision informed by UiM physicians' current and historical experiences of discrimination in medical education (Wright-Mendoza 2019; Steinecke and Terrell 2010; Poole et al. [published online ahead of print]; Beagan 2005, 2003, 2001, 2000). This second level of coding revealed how participants' professional identity is influenced by medicine's culture of Whiteness.

The team then took their interpretation back to participants for member checking in November and December 2019. An email was sent to all participants inviting them to comment on the interpretation. All participants who responded (6 students, 2 residents, and 4 physicians) participated in a second phone interview in which the team's interpretation of the data was presented, and participants commented on the ways in which the interpretation fit their experiences. After adjustments were made, the findings were then organized using the post-colonial concept of *palimpsest* (Ashcroft et al. 1995) to draw greater attention to the dominant ways PIF is thought of and the ways in which UiM physicians described their PIF.

Palimpsests are actual historical documents or pieces of writing material where two sets of inscriptions are visible; one inscription is visible written as the topmost layer, and the other is partially erased, yet still visible underneath the newer text (Ashcroft et al. 1995). Palimpsest was used as an analytical metaphor to represent the presence of two different "texts" in the PIF literature; one dominant and clearly read in medical education, and one running underneath, yet only visible when UiM physicians were studied as a separate group. We organized the results in this way to demonstrate how a dominant conceptualization of PIF has been forwarded and how it relates to those of UiM physicians. The Institutional Review Board at the Medical College of Georgia, Augusta University approved this study.

Findings

The dominant PIF literature is concerned with how trainees are socialized into the medical profession and internalize the values, beliefs, and characteristics associated with becoming a physician (Cruess et al. 2015). However, Black/African American physicians describe an awareness of medical education's history of exclusion that is not captured in the dominant PIF literature (Cruess et al. 2015), which has made Black physicians on alert and watchful

as they are socialized into being members of the medical community. Overall, the culture of medicine is perceived to be precarious for Black professionals because of issues of racism and discrimination that has been found elsewhere in medicine (Beagan 2001). Therefore, the participants in this study focused on the development of their ethnic and racial community and challenging the larger social, historical, and cultural mistreatment of Black Americans within and outside of medicine, far-reaching concerns that are currently not captured in the dominant PIF literature.

On alert when joining the community: "keep your eyes open. Always watch your back"

The PIF literature assumes that by virtue of choosing the profession and entering medical school, in time trainees will be socialized into and become full members of the medical community (Cruess et al. 2014; Vivekananda-Schmidt et al. 2015; de Lasson et al. 2016). However, this assumption rests on the idea that the culture of medicine is one that is welcoming to ethnically and racially diverse physicians, which the participants expressed was not the case for African Americans whose values, beliefs, and characteristics were not included in the historical evolution of medical education. The Flexner report created numerous historical and structural barriers that has kept African Americans out of medicine and students described not feeling safe because they consistently heard messages that they do not belong: "[My peers] either outright stated or insinuated that [African Americans] may not be capable of [being successful in medicine]" (Student 2). In other contexts, such as clinical settings, participants received these same messages, often mistaken for being a nurse, janitor and other staff member.

These kinds of interactions were reminders for participants that the profession historically excluded UiM physicians, such that they are generally not well-recognized as physicians. Participants may have been *both* Black *and* a physician, but do not perceive themselves as full community members, even at the level of the attending. They describe needing to keep a watchful eye on their White peers, as this physician explained, "I pay attention to assumptions. I pay attention to tone. I pay attention to glaring opportunities, missed conversation. I pay attention to who's not in the room, who's not involved, to what's not being considered" (Physician 7). Even if they chose not to pay attention, others from their community did so on their behalf, as one resident described:

> Most of the ancillary staff around me are Black. They always come up to me and they're so happy to see me, but they always give me little side comments like, 'Always keep your eyes open. Always watch your back. It's not what it seems.'…. [Others tell me] never get comfortable, just know what the situation is" (Resident 4).

Participants indicated they are always on alert and watchful because medicine lacks an adequate number of Black physicians to make their existence commonplace. Currently, the number of Black/African American physicians is estimated at 6% (Williams 2018). As a result, they experience microaggressions, or daily, subtle indignities that draw attention to their race/ethnicity. These messages continuously communicate that they don't belong in the profession, which is then reinforced through a process of continuous transference. One physician described this experience, "When you step up to a group that's not used to a lot of minorities, very small things trigger [reminders that I am not safe], and then it takes you back and you go, 'Oh, wow. We're back here again'" (Physician 2). Interactions with their White peers are constant reminders of Black physicians' outsider status and the larger

historical forces that have shaped their current position. In systems and professions dominated by one racial group, there are constant reminders of a larger socio-historical context of exclusion communicated to minoritized groups.

Attendings described their professional identity in terms of spending a great deal of time helping trainees feel as if they belong. For example, one described consistently telling residents to embrace the incredible challenge they have gone through to be a Black physician within a White profession, "Be proud of the accomplishments that you already made, because you are a doctor. Nobody gave that to you. Nobody can take that away from you. You earned that" (Physician 5). In other cases, residents described thinking about themselves from an outsider's perspective as a way to brace for the stereotypes of what a doctor looks and sounds like in the medical profession, "[You need to] create your own narration and story for those people on the outside looking in that don't think it's possible. You show them that you can look and act a certain way and still do this profession" (Resident 4). These comments reflect the isolating nature of being a Black physician in a profession that is primarily comprised of White professionals. Whereas for a White physician moving into a White profession this process may seem unproblematic, but for UiM physicians, the socialization process invokes larger socio-historical issues. As a result, becoming a physician and becoming a member of the community includes keeping a watchful eye out for oneself and others.

Engaging in racial uplift: "I had to think of a way I would give back to my community"

The dominant PIF research does not highlight how social commitments outside of medicine influence trainees' and practicing physicians' PIF. Rather, the boundary around what is studied is typically limited to examining participants' experiences of PIF within the training system. However, in this study, UiM physicians described using their professional influence as Black doctors to engage in racial uplift, the idea that successful African Americans reach back into their community to bring others out of oppression. This interest in engaging with racial uplift increasingly became more visible towards the latter part of participants' career and was frequently expressed as a feeling of responsibility to other Blacks/African Americans both in and out of the profession.

Students discussed how being Black influenced their choice of specialization because they wanted to help the social conditions within their racial/ethnic community, "I had to think of a way I would give back to my community through this field. [I thought] about the patients that I would be responsible for and [how I could have a] connection beyond just being their doctor" (Student 2). Residents described how thinking about one's community is natural and reflective of what it means to be a Black physician, "As you are coming up, you are always aware of the people coming behind you. This extends into beyond training and into what kind of job you take" (Resident 9).

These comments demonstrate that Black physicians are less concerned about their own careers and becoming professionals as the dominant PIF research might suggest (Cruess et al. 2015) and more concerned about their ability to assist other African Americans in being treated well. This was expressed succinctly by this physician: "Part of being a good doctor, or my professional identity is to make sure people are treated equally and respectfully in ways that would make sense to everyone" (Physician 12). These comments demonstrate that UiM physicians' professional identity is influenced by factors outside the medical community that extend into their ethnic/racial and home community. Race/ethnicity

influences their professional identity in training (Beagan 2003), but also invokes larger issues of how trainees' use their professional identity around issues of inequity.

All participants actively looked for means to assist their community. For example, one physician described how her White residents frequently "had issues with African American patients," such as blaming them for not being able to clearly provide a medical history or not complying with medical regime. Hearing these stories helped her realize that there was more to being a Black doctor than just thinking about her own training,

> I wanted to make sure that the people that were caring for people that looked like me knew how to do it. In terms of not just the knowledge, but more of the connection, you know what I mean? The caring and connecting piece, as opposed to just following the recipe of how to care for congestive heart failure (Physician 10).

Racial uplift, as part of their professional identity, was discussed as a communal responsibility, one that would have been integrated regardless of their chosen profession. Participants described it originating from a combination of family values and the African parables that emphasized "it takes a village to raise a child." Black patients frequently reinforced this value telling trainees "I am so proud of you" in clinical encounters. Such comments reinforced UiM physicians' feelings of responsibility for their community, and worked synergistically, as this resident described, "When I walk in the room, I really feel like I'm talking to my cousins or my aunt or my grandma and it changes the entire dynamic" (Resident 1).

Even students early in their training felt this sense of responsibility. Many described using their accomplishments as a physician to tutor others, mentor other medical students, or talk with young children living in underserved neighborhoods. In having been successful themselves, they did not want to let those coming behind them in their training to have to navigate it alone. In every case, participants expressed concern for the next generation whether the African American was a patient or a trainee. This commitment was made for their entire racial/ethnic community as this physician shared, "It's important to me… [to] not forget to look around and reach back to the people who come from a similar background, who may feel uncomfortable in this environment" (Physician 3).

Being a mentor: "UiM groups need more support by any means necessary"

The importance of mentorship is viewed as critical in the development of a professional identity; however, UiM physicians discussed, not just being mentored, but *being a mentor* as important. For these UiM physicians, being a mentor is critical to forming and informing what it means to be a doctor. Participants explained that in a professional culture where Whiteness prevails, mentoring is an important means to ensure the success of other UiM physicians within the profession, "People from UiM groups need more support by any means necessary….It could be from someone who is from a similar background or not. Having those affirmations and support is important for UiM trainees" (Physician 6). While many did not feel they could directly address the culture of Whiteness, they could become leaders and provide assistance in helping others navigate the training and practice system.

For example, students mentored high school students in math and the medical college admission test if they were interested in practicing medicine. They also assisted younger medical students to understand what to focus their attention on in a curriculum that was overwhelming. This was illustrated in multiple comments from students that talked about how taking leadership opportunities was part of their professional identity. Being *both*

Black and a physician *and* a leader in the community were integral, "Being a leader is another part of my professional identity that's been developed through medical school…. No matter what I end up doing, I will very likely find myself in some position of leadership" (Student 5).

Additionally, residents discussed how they mentored students, meeting regularly with younger UiM trainees "to see if they are on track with their studies," and other residents interested in understanding how to be a successful Black doctor (Resident 9). Attendings discussed mentoring all UiM physicians to ensure their success in medicine, "[I mentor] Black and brown people with intentionality…. I use my position in many different domains to encourage, push, and ensure… faculty of color" (Physician 10). Mentoring as a form of leadership was integral to their professional identity because it allowed participants to be leaders in the Black community, as this physician described:

> As I moved into leadership, being a Black woman, I had authority to change the narrative. [This is when] leadership became a part of my professional identity. I leveraged my street cred, if you will, to publish and speak as an authoritative voice [as a Black person in medicine] (Physician 12).

Others extended leadership beyond clinical and classroom settings and reached into spaces where African Americans gather, as this resident described,

> I can tell you that most churches that have physicians educate the church community about medicine, mentoring young teenagers and children. You feel this connection of [Black physicians' commitment] deep into the community that extend beyond the walls of the hospital (Resident 9).

The PIF experiences gathered from these UiM physicians indicate a major aspect of their professional identity is to be a leader in their community. Medical school may provide a training context for them to become doctors, but it is their sense of responsibility and commitment to their community that provides direction and influence in shaping their professional identity.

Discussion

This study demonstrates that the PIF experiences of Black/African American physicians is influenced by the sociohistorical context that excluded them from medical training for nearly a century, and the culture of Whiteness that was allowed to permeate during their absence. The findings reveal that Black/African American physicians, like all trainees, are eager to join the medical community, but are watchful and on alert as they do so. They suspect the training environment may not be safe for their ethnic/racial group, which is reinforced through interactions reminding them of their outsider status. As they work on strategies to navigate medical education, UiM physicians remain tightly connected to their ethnic/racial community and engage in various forms of racial uplift both within and outside of medicine. They also actively seek out leadership positions that would allow them to use their professional position to improve the conditions for other Blacks/African Americans in the U.S.

These findings confirm that UiM physicians' PIF experiences are not reflected in the dominant PIF literature and that medical education has forwarded specific views of PIF to the exclusion of others. By studying physicians as a homogenous group and

considering UiM physicians' unique sociohistorical context, it is clear that a dominant view of PIF has obscured the field's ability to conceptualize professional identity in ways that exist outside the dominant perspective. As a result, PIF researchers have primarily focused their research on how clinical (Weaver et al. 2011; Konkin and Suddards 2012) and preclinical (Niemi 1997) experiences inform the training of physicians and neglected how other sociocultural variables and historical context may inform one's professional identity.

This study has several important implications for medical education and PIF research. First, participants indicated that being *both* a mentor *and* a mentee are important influences on their experience of PIF. Whereas, the dominant PIF research only focuses on the role of models (Passi 2016) and mentors (Hazen et al. 2018) in the creation of a professional identity, UiM physicians indicate *being a mentor* is a critical part of PIF, and this idea that *being a mentor* may have direct implications for what many UiM faculty describe as the "minority tax" (Rodriguez et al. 2015; Campbell and Rodriguez 2019). The minority tax is the extra burden and responsibility for mentoring placed on minority faculty in the name of diversity. It is considered a major source of inequity in medical education because it falls primarily on the shoulders of UiM physicians. However, the results of this study show that Black/African American physicians mentor UiM trainees to assist them in successfully navigating the harsh training environment that was created in their community's historical absence.

Therefore, if medical education wants to support UiM physicians, they must recognize that mentoring is a part of their professional identity and integral to the success of UiM trainees' careers in medicine. Non-UiM physicians must play a greater role in helping to alleviate the burden that rests primarily on this group to shepherd new UiM trainees into medical education. We suggest that medical education begin to reduce this burden placed on UiM physicians, and harness the potential of non-UiM physicians to assist in this effort; an effort that may be called a "majority tax". The majority tax is the "taxation" that non-UiM faculty members accept to support the success of UiM physicians as a way to acknowledge and recognize how the Flexner report shaped the harsh training environment that UiM trainees experience (Osseo-Asare et al. 2018; Campbell and Rodriguez 2018). Examples might include speaking up when non-UiM physicians hear discriminatory remarks made about UiM physicians, taking on mentoring with UiM trainees, and actively assisting UiM physicians with engaging in racial uplift efforts.

The second implication for medical education is related to UiM physicians' access to leadership positions within academic medicine. To date, studies show that UiM faculty endorse higher aspirations for leadership positions in academic medicine compared to their peers (Pololi et al. 2013a), yet many have a lower sense of inclusion, trust, and relationships compared to their non-UiM peers. When high leadership aspirations exist alongside these negative feelings, there is greater likelihood of faculty intending to leave academic medicine (Pololi et al. 2012). Therefore, issues of inclusion, trust, relationships, and even a sense of belonging within the medical profession all have direct implications for the recruitment, retention and career progression of UiM physicians (Cregler et al. 1994).

To address UiM physicians' desire for leadership positions, greater consideration must be given to Black/African American physicians' leadership aspirations in academic medicine. These positions should not be limited to just Offices of Diversity, where their responsibility is primarily to address issues targeting the needs and support of UiM trainees. These positions should include those at the level of the institution (Smedley et al. 2004; Fang et al. 2000; Pololi et al. 2010) where decisions about the education and training environment are made.

UiM physicians' presence at this level is crucial to improve the overall diversity within medical education evidenced by previous work that found UiM physicians are able to identify problems and generate solutions in ways that may only be visible to minoritized individuals (Nivet 2010). UiM physicians' presence in these positions also demonstrate medical education's commitment to ethnic/racial diversity. Medical education must recognize that UiM trainees occupy a specific social position that is endowed with perspectives and experiences that can only be understood by other minoritized individuals.

The third implication for medical education is that the profession must pay greater attention to the overall culture of Whiteness embedded in medicine's values, beliefs, and practices, and how this culture affects those ethnic/racial groups who are new to medical education. Although research indicates that changing culture of medical education has enormous potential for creating environments that support UiM physicians (Pololi et al. 2013b), changing the culture of Whiteness may be more challenging. DiAngelo (2011) shows that White people in North America live in a social environment that protects and insulates them from issues of race that might otherwise cause stress. This protected environment facilitates what is known as a state of *White fragility*, which makes any race-based issue trigger a range of defensive moves, such as anger, fear, and guilt, as well as a willingness to argue, silence, and leave conversations that include issues of race. These reactions to uncomfortable topics benefit Whites' sense of overall well-being, and function as a way to reinstate White racial equilibrium. White fragility may make it extremely challenging to change the culture of medicine and training environment to reflect what UiM physicians need, but continuous effort to this end must be made.

In addition to implications for medical education, this study has several implications for PIF research. Namely, researchers should include wider conceptual and methodological boundaries, including nested socio-historical contexts, the ways the culture of Whiteness is preserved in our organizations and professions, and the role ethnic/racial communities influences PIF (Hodges 2005). Wider lenses and approaches are needed because the professional identity of minoritized individuals functions within an individual in ways that are very different when compared to non-minoritized individuals (Slay and Smith 2011). As a result, numerous assumptions continue to be forwarded in PIF research, and need to be explicitly addressed in future work. To this end, we encourage greater emphasis on *absence research*, research that explicitly examines areas within health profession's education that are under-described, yet have potential to enhance and develop the field (Paton et al. 2020). Absence research has the potential to help the medical community not only see what is before them, but what is not there and should be.

We also suggest future research study the culture of Whiteness and its influence on the development of a professional identity for other minoritized groups. For example, students, residents, and attendings with other UiM designations, such Latinos, Native Hawaiians, Native Americans, Native Alaskans (American Association of Medical Colleges 2004) should be studied for their own PIF experiences. Additionally, trainees and physicians who are not considered UiM, but still minoritized in the U.S., such as Chinese, Indians, and others should be given their own research agenda (Ko and Ton, Published Ahead of Print). These groups exist within their own unique socio-historical contexts and experience PIF issues that have yet gone unexamined.

Finally, we suggest further investigation into how medicine's hierarchy may influence UiM physicians' PIF. Although participants at all points of their career were aware of the culture of Whiteness and the deleterious effect it had on themselves and other Black physicians, they seemed to better understand how to maneuver within it later in their career. This finding is consistent with new research, which demonstrates that while many Blacks/African Americans

experience an enormous amount of racial discrimination in the workplace regardless of their position, yet influenced by where a minoritized individual is in the organizational structure (Wingfield and Chavez 2020). In other words, the culture of Whiteness engulfs everyone, but there are some who have developed strategies for working within it and bringing up other Black/African American physicians. This level of attention to where minoritized individuals are within an organization hierarchy and its affect on their PIF must be explicitly be recognized.

Although this study has helped to forward new conceptualizations of PIF research, there are several limitations that need to be considered in ways that challenge this line of inquiry, including that the selection of participants was conducted via the snowball method, which may have been influenced by our personal and professional networks. Participants were also in academic medical centers, which many Black physicians are leaving because of the institutional culture of Whiteness and repeated traumatization found in this setting (Blackstock 2020). Recruitment in academic medical centers may have unintentionally left behind only those Black physicians who were able to resist the unequal treatment they have experienced. Other studies should examine PIF in Black physicians within the private sector to better understand the extent to which these physicians experience PIF in ways described in this study, and ensure the findings of this work are properly contextualized.

Finally, we have to acknowledge that this study was conducted in the Southeastern part of the U.S., an area of the country that is known for its historical, social, and racial strife and deep distrust between the Black/African American community and medicine (Washington 2006). The state in which these physicians live and work actively enforced racial segregation until 1964 when the Jim Crow laws were abolished. Although the U.S. as a whole struggles with issues of racial tension, the South is known as a hotbed of racial issues that includes the brunt of American slavery, political unrest and racial divide, and the birth of the civil rights movement (Egerton 1995).

Without further research, it is difficult to know if the issues described by participants in this study are shared across other Black/African American physicians in different parts of the country, or if the unique cultural context of the American South may have amplified or articulated these issues. Therefore, future research should explore PIF among Black/African American physicians in other geographical locations, taking into consideration the unique socio-historical context of their history, alongside their practice and training settings.

Finally, we can't help but wonder what wasn't said in the interviews and what was too hard to describe or too painful to voice. Spivak (1988) reminds us that those who are in minoritized positions struggle to find space in the dominant discourse to express what they feel is important. Although we assembled a racially/ethnically diverse research team to assist with the data collection and analysis, the participants may have chosen not to share some of their experiences. It could be that our line of questioning or framing of the issue led them in one direction when different questions could have led elsewhere. We also wonder if there were aspects about being a minoritized individual in a White profession they had not yet articulated even to themselves, and therefore did not come out in the data. Again, future research on the PIF of UiM physicians can help fill out their experiences.

Conclusion

Dominant perspectives silence the voices and experiences of minoritized groups in many areas of research, as well as in the study of PIF in medical education. It is crucial for the medical community to critically evaluate the use of normative frameworks that exclude minoritized populations. Creating a more inclusive medical community through purposeful mentoring of UiM students and physicians will benefit the medical community as a whole, as would greater attention paid to the ways in which our current PIF research forwards dominant perspectives.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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