POINTS OF VIEW

Resilience — The Last Thing We Need

"Celeste is overconfident . . . arrogant . . . ." Blinking back tears, I kept reading: ". . . she acts like she knows more than she actually does." Two months into my blisteringly paced Ob/Gyn residency, I was meeting with my labor and delivery (L&D) rotation director for feedback. We reviewed praise and constructive commentary from my peers and attendings: I was a natural in the operating room, easily established rapport with patients; I needed work on time management and brevity in my patient presentations. Saved for last was this handful of anonymously written complaints from some nurses. Through my embarrassment, disappointment, and confusion, my mind raced, trying to interpret the underlying messages: *Am I too confident for a woman . . . or for an intern? Is my self-assurance deemed arrogance because I'm Black?*

Though I'd modeled my communication, clinical work, and behavior on those of my cointerns, none of them received similar criticisms. As one of only two Black trainees in a program of 28 residents, I wondered whether the personality-related comments were linked to my identity as a Black woman. My rotation director advised me to be deferential, to appease egos and try to make the time pass more pleasantly. Though she described her own attempts as an intern to curry favor with nurses, what I really needed was an attending who could recognize the dog whistling in words like "overconfident," "arrogant," "overbearing." They were iterations of the racist stereotype of the "angry Black woman"; they could not be taken at face value, especially coming from a small subset of a predominantly White nursing cohort.

Most new doctors, and even medical students, describe experiencing hazing from seasoned nurses and more senior physicians — a twisted rite of passage.[1] Black and Brown trainees receive even more such mistreatment.[1] Although it typically diminishes with each year of residency, the damage piles up on a trainee of color: not only is she responsible for her clinical learning, but she must also constantly reaffirm her competence and her rightful place in this world.[2] Navigating racism as a Black physician often feels like being the first person in a group to walk through a spider web: those behind you watch as you panic, swatting the air to free yourself from an affront that no one else can see or feel; they can either believe that there was a web in your face or dismiss your experience and call you crazy.

Black physicians traverse these spider webs throughout our careers. We become masters of code switching; we soften our voices so we're perceived as nonthreatening. On teaching rounds, we're used to being ignored by patients who assume the senior team member is the White male student towering over us. Black women physicians are oversexualized and told to reconsider our career choices, to better utilize our "childbearing hips," as a faculty member told my mentor during her medical school interviews. Despite sometimes feeling invisible — we account for only 9.4% of medical students, and less than 5% of medical school faculty — "still, like dust, [we] rise."[3] Over time, repeated jabs at our self-esteem give rise not to resilience, but to the academic equivalent of Arline Geronimus's "weathering." Feeling undervalued and isolated, we burn out early.

I shared the feedback I'd received with a friend who was our only Black maternal–fetal medicine fellow and a graduate of my program. She'd experienced similar hazing from L&D nurses, whereas her White classmates had not. She, too, had been called "spicy" or "sassy" or had her treatment plans challenged in front of patients. Though I tried to let the negative comments roll off my back as she advised, I couldn't find my rhythm again for months.

Over the next 4 years, I worked to nurture a supportive environment for trainees who are underrepresented in medicine (URM). From coauthoring an antiracism statement after George Floyd was killed to launching a lecture series on health disparities, I strove to ensure our department was publicly and unequivocally vocal against

racism and discrimination. These added duties strained my well-being, but I felt obligated to help make my program more inclusive and self-aware.

Today, I think of the trainees who continue to feel isolated despite their programs' promises to pursue diversity, equity, and inclusion. Residency leaders must actively foster protection and support for trainees who will be in the minority in nearly every setting; an inclusive environment will improve the experience of all residents.

Residency programs could, for example, display in clinical workspaces policies for reporting perceived mistreatment, discrimination, and intolerance. They could train faculty to recognize and respond to racism and microaggressions against trainees. They could discard evaluations that lack specific examples, particularly those remarking on communication style (e.g., "loud," "aggressive"), physical appearance, or disability; feedback unrelated to clinical performance or educational milestones should be considered irrelevant. And they could incorporate mentorship of URM trainees into tenure requirements.

I finished residency with my optimism intact — but not by accident. I was lucky my program director validated my experience in receiving the offensive feedback, even though she couldn't personally relate. I was lucky my department agreed to make practical changes to improve equity and inclusion. Above all, I was lucky my diverse, passionate coresidents never hesitated to speak truth to power and fight for greater inclusivity.

Marginalized residents should not have to rely on luck. In pursuing equity and inclusion, residency leaders should consider practical ways of creating an environment conducive to residents not only surviving training, but thriving.

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Disclosure forms provided by the author are available at NEJM.org.

1. Hill KA, Samuels EA, Gross CP, et al. Assessment of the prevalence of medical student mistreatment by sex, race/ethnicity, and sexual orientation. JAMA Intern Med 2020;180:653-65.
2. Wilson S. Gaslighting of Black medical trainees makes residency something to 'survive.' Boston: STAT, March 10, 2022 (https://www.statnews.com/2022/03/10/gaslighting-black-medical-trainees-residency/).
3. Still I rise. In: Angelou M. And still I rise: a book of poems. New York: Random House, 1978.

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