Education

Identifying, Addressing, and Eliminating Microaggressions in Healthcare

Tracy MacIntosh, MD, MPH, FACEP[1,2]; Michelle Hernandez, MD[2]; Anuja S. Mehta, MD[1,3]

Author affiliations are listed at the end of this article.

Correspondence to:
Tracy MacIntosh, MD, MPH, FACEP
UCF College of Medicine
6850 Lake Nona Blvd
Orlando, FL 32827
(Tracy.macintosh@ucf.edu)

Abstract

Description

Microaggressions are pervasive throughout society, including in healthcare and academic institutions. They are often unconscious but accumulate over time, and they negatively impact the recipients' productivity and achievement by creating a sense of inadequacy as well as a lack of belonging. We outline several evidence-based strategies and teaching frameworks that institutions and training programs can adopt to reduce the prevalence and impact of microaggressions against trainees from historically marginalized groups, and that can promote psychological safety for everyone.

Keywords

microaggression; medicine/statistics and numerical data; minority groups; medical students; physicians; cultural diversity; social discrimination

Introduction

Microaggressions in Healthcare and Academic Medicine

Isabel is a new intern starting her Emergency Medicine rotation. She is nervous about her first rotation in a brand new city and hospital, and she is still learning the electronic medical record system as well as the names of her colleagues. She is excited about her new level of autonomy, the chance to learn medicine, and the opportunity to take care of patients. As the senior resident, you enter the first patient's room together to help her get acclimated to the department. She walks in first with a big smile and introduces herself. She explains her role as the resident physician and asks the patient how she can help him.

He sits up straight in bed, looks past her at you, and says: "Hey, you wait just a minute! I don't want a doctor with an accent. I want a real doctor! You need to go back where you came from!"

What do you do?

Increasing the representation of individuals from groups that have been historically under-represented in medicine (URM) is a well-recognized national priority. Yet, there are still lower application and matriculation rates for URM students in medical schools.[1] Increasing diversity is not only the equitable thing to do but is essential for improving patient outcomes, ending health disparities, and driving scientific innovation.[2-4] Members of under-represented identities often face prejudice and other forms of discrimination throughout their educational and professional careers, with almost one-third reporting individual and institutional-level challenges in their careers.[5] One vital way to address this disparity is by enhancing the learning, clinical, and work climates by focusing on diversity and inclusion to create environments that are supportive and welcoming to all individuals. This article addresses the impact and pervasiveness of microaggressions in the healthcare setting. It reviews evidence-based

strategies and teaching frameworks that institutions and training programs can adopt to interrupt microaggressions and promote psychological safety for all trainees and team members.

The term "microaggression" was first coined by Harvard psychiatrist Chester Pierce in the 1970s, and a growing body of research has begun to elucidate the extent, impact, and consequences of microaggressions across a broad range of settings.[6] Microaggressions are pervasive in society at large, including institutions of learning. They disproportionately impact students of color, first-generation college students, and students identifying with historically marginalized groups (race, ethnicity, gender, sexual orientation, religion, disability, etc.).[7] Since microaggressions occur so frequently, they can accumulate over time and negatively impact recipients' productivity and achievement by creating a sense of inadequacy as well as a lack of belonging.[8]

Although overt acts of discrimination are less prevalent, many acts of bias and prejudice remain pervasive, both in society and academic institutions, and can manifest in unconscious, implicit ways. Microaggressions are subtle, frequent statements, actions, or behaviors that transmit implicit denigrating messages to marginalized and historically oppressed populations. They may include assumptions of inferiority, second-class citizenry, criminality, invalidations, and/or exoticization. They are highly pervasive and occur throughout society, including in the workplace and educational settings.[9] Microaggressions negatively impact academic performance and can lead to additional stress, anxiety, impaired concentration, and depression.[10,11] Workplaces that are not inclusive and welcoming can also cause social identity threats, as individuals recognize that they are not valued. Murphy et al. report that this phenomenon leads to cognitive and physiological vigilance and lack of engagement, which hinder productivity and innovation.[12]

In order to cultivate and retain diverse healthcare leaders throughout our nation, we need to create learning and training environments that are inclusive and supportive. We need leadership and faculty at academic institutions to develop policies, practices, and strategies that leverage diversity and support all learners. We also need faculty, staff, and trainees who understand their roles as sources, recipients, and bystanders of microaggressions, as well as their impact on the culture and climate of our healthcare institutions.

Psychological Impact

In the landmark paper "Racial Microaggressions in Everyday Life," Sue et al. describe 4 different types of microaggressions: microassaults, microinsults, microinvalidations, and environmental microaggressions.[13] See **Table 1** for a description and example of each of these types of microaggressions.

URM trainees are often the recipient of one or more of these types of microaggressions in their clinical settings. The term "micro" refers to the repeated and commonplace occurrence of these transgressions, which can severely affect their well-being over time. Studies have shown that microaggressions are associated with anxiety and depression among those who experience it.[14,15] Experiencing microaggressions can lead to burnout among URM learners.[10] Feelings of low self-esteem, shame, and a decrease in confidence can naturally result when a supervisor who is perceived to be in a position of power over the trainee engages in microaggressions. The cumulative impact of microaggressions endured during medical education and residency training can have a long-lasting effect, reducing one's potential to succeed in academic careers. Black and Latinx physicians comprise only a small percentage of medical school faculty nationwide despite representing 13% and 18% of the US population, respectively.[16,17] Therefore, focused strategies for recruiting and retaining a diverse healthcare force are essential.

It is important to note that medical students and residents are already at a higher risk for stress and burnout than their age-matched peers due to the intensity of medical training and the stressful nature of their work.[18] The additional burden of microaggressions experienced by URM trainees at work increases their risk for mental strain and can result in poor performance as well as low academic achievement.[19] With the exception of microassaults, which are intentionally produced by the perpetrator, the other forms of microaggressions

Table 1: Four Types of Microaggressions with a Corresponding Example

Types of microaggressions	Example
Microassault	A program director repeatedly mispronounces an Asian resident's name despite being informed of the correct pronunciation by other faculty and staff
Microinsult	A Black psychiatry resident is confused for a care companion by a nurse
Microinvalidation	An attending refers to a female resident as "too sensitive" during rounds when she started crying in front of a patient's family
Environmental microaggression	Posters show solely heterosexual couples in the office waiting room

are often unintentional but can cause serious psychological harm to the recipients. Researchers studying microaggressions draw an essential distinction between their intent and their impact. In most cases, when someone commits a microaggression, the perpetrator does not have malicious intent toward the recipient. However, that does not change the damaging impact microaggressions have on the recipients.[10]

Strategies to Promote Communication and Collaboration

Some colleagues and patients may be resistant to acknowledging microaggressions, asserting instead that "people are just too sensitive" or "woke"—a recent term commonly used to describe individuals who are aware of, and seek to act on, issues of racial and social injustice.[20] It can be challenging to engage a colleague or supervisor in a productive conversation where they have been the source of the microaggression. Still, we find the framework provided by Ackerman-Bager et al. below useful in engaging sources of microaggressions in non-confrontational conversations.[21] This framework focuses on helping the source or bystander in a microaggression incident understand the impact of their words or actions and outlines the next steps in the interaction.

How to Create a Non-Retaliative Culture

Daily experiences of URM health professionals are affected by microaggressions.[10] Microaggressions have been shown to have a dose-response with depression and anxiety and can disrupt the learning environment.[10] The more an individual experiences microaggressions, the higher the likelihood of developing negative symptoms from the experience. Although increasing the diversity of health professions has rightfully become a national priority, health professional schools still struggle to recruit historically marginalized students. It is not enough to merely increase diversity in the workforce. We must focus on practicing inclusiveness and providing environments where all members can thrive. It is crucial to create a non-retaliative culture to address microaggressions early on in academia.

Ackerman-Barger et al. proposed the Microaggressions Triangle Model as a framework to understand and address microaggressions.[21] The framework encourages individuals to view microaggressions from 3 different perspectives: the recipient, the source, and the bystanders. These various perspectives allow for a better understanding of the situation for all those involved, especially since there are threats to all individuals during a microaggression. The recipient may be seen as oversensitive, the source as racist, and the bystander(s) as cowardly. This framework provides a non-threatening way to engage in difficult conversations and enables all individuals to address the issue and, hopefully, spark dialogue and self-reflection.

In the following example, consider the microaggression where the male attending, “Dr. B”, calls a female resident "sweetie" in the clinical environment in front of colleagues. In this case, using this term of endearment in the professional workplace is inappropriate and can feel condescending. While the source may believe their intention is friendly, it can invalidate and diminish the professional qualifications of the

recipient. Recommended actions for each individual involved in a microaggression are outlined below, along with possible responses.

The Microaggressions Triangle Model[21]

The *Recipient* response is **ACTION**
- **A**sk a clarifying question
- **C**ome from curiosity, not judgment
- **T**ell what you observed in a factual manner
- **I**mpact exploration
- **O**wn thoughts and feelings about the subject
- **N**ext steps: Will you address this issue now or later?

Examples of recipient responses in the moment and addressing it later:
- Recipient in the moment: "Good morning, Dr. B. Although I know you had good intentions, I felt uncomfortable when you addressed me as 'sweetie' instead of by my name because it made me feel like my role as a medical doctor on this team was not being respected."
- Recipient addressing it later: "Hey, Dr. B. Remember when we worked together yesterday? I have been thinking about how you called me 'sweetie'."

The *Source* Response is **ASSIST**
- **A**cknowledge your bias
- **S**eek feedback
- **S**ay you are sorry
- **I**mpact, not intent
- **S**ay **T**hank you

Example of a source response:
- Dr. B: "When I called you 'sweetie', I thought I was being endearing. However, now that I have reflected on what I said, I see that it was inappropriate. I am sorry. Will you give me a chance to do better in the future?"

The *Bystander* response is **ARISE**
- **A**wareness
- **R**espond with empathy; avoid judgment
- **I**nquiry example: "What did you mean by that?"
- **S**tatements that start with "I"
- **E**ducate and engage

Example of a bystander response :
- "Hi, Dr. B. I wanted to follow up with you about an interaction I saw yesterday when you called her 'sweetie'. I am concerned you made her feel inferior and uncomfortable. I noticed her face change. I think it may not have come out like you thought. I wanted to let you know because we have worked together for a while, and that statement does not align with who I know you to be."

Focus on Impact

The framework above is effective because it addresses the impact of the microaggression rather than focusing on the intentions, biases, or insensitivity of the source of it. Therefore, this framework avoids placing blame or pointing fingers. It also allows the conversation to explore the implications of microaggressions on patient care, team morale, productivity, and employee engagement and retention. The discussion should focus on how addressing and eliminating microaggressions will ultimately lead to more positive and productive places to learn, provide patient care for everyone, and how microaggressions lead to toxic work environments.

Points Throughout the Curriculum

The goal is to promote a genuinely inclusive culture and, ultimately, a safe environment for all learners and team members to feel valued and thrive. To address these issues, we should start teaching this framework as early as possible. We can begin in middle school and continue all the way through graduate school and residency training. Research has demonstrated that intentional training on microaggressions is impactful in preparing learners to address them in meaningful ways. One study provided training on microaggressions for medical and dental students prior to starting their clinical rotations. Sandoval et al. created a 2-hour workshop to prepare preclinical medical and dental students to respond to microaggressions.[22] This workshop included a didactic portion and a case-based small group portion to practice the strategies that were taught. The workshop provided readiness to address microaggressions and practice in a supportive environment.

Ackerman-Barger et al. completed a similar study where 6 workshops were implemented at 3 different institutions and delivered to nursing and medicine faculty, students, and leaders.[23] The authors found statistically significant improvements in participants' knowledge of the impact of microaggressions, self-efficacy in responding to microaggressions, and commitment to being an active bystander in the face of microaggressions.[23] Participants also reported being highly satisfied with the training. This study demonstrated that participants felt better equipped to manage microaggressions and engage in potentially difficult conversations that can ultimately promote inclusion after just one session.

Workshops should be implemented at least twice per academic year into the graduate medical education (GME) curriculum as a framework to think critically about microaggressions. In between workshops, discussions about microaggressions and their harmful impact should occur regularly during lectures, as discussed below. Case-based learning during workshops should guide conversations to build and promote inclusive excellence. Key points should include preventing microaggressions, repairing and reestablishing relationships when microaggressions occur, and restoring reputations after the microaggression has happened.[10]

Faculty and leaders should implement strategies that create innovative problem-solving so that all learners reach their academic potential. They should implement sessions geared toward faculty and residency leadership to create a safe space for leaders to practice and discuss ideas for change. Some of the faculty at our institution conducted a faculty development session on how to create a safe and transparent learning environment. They introduced the Microaggressions Triangle Model and described the difference between intent and impact. The session also provided several clinically-based examples of microaggressions, discussed strategies to promote a safe and transparent learning environment in a residency program, and provided a space for faculty to engage in this topic in a self-reflective and protected space. We promote inclusiveness and restorative justice in our clinical and academic workplaces by creating dedicated workshops and forums for discussions on microaggressions and belonging for learners, faculty, administration, and leadership. The medical community must strive to mitigate microaggressions to create an inclusive learning environment.

Best Practices for UME, GME, and Administrators

Undergraduate medical education (UME) and GME institutions and programs have an obligation to create a psychologically safe and inclusive environment for trainees from historically marginalized groups who are most likely to be the recipients of microaggressions in the workplace. Research on microaggressions and unconscious bias has expanded in the last several years, with several examples of curricular materials and training available online that programs can administer to faculty, students, residents, and staff.[24] At a GME level, program leadership should use these materials to train all their faculty, residents, and staff on microaggressions.

The role of implicit or unconscious bias in microaggressions cannot be understated. As previously stated, most microaggressions are committed unintentionally and can stem from layers of unconscious discrimination against students and trainees from historically marginalized groups. A group of scientists from Harvard University, the University of Virginia, and Washington University developed a series of Implicit Association Tests (IATs) on several topics to determine how individuals act based on their deep-seated, unquestioned assumptions about their environment and other people.[25] IATs exist on a wide variety of issues relevant to the clinical learning environments and can provide a measure of the implicit bias among faculty, staff, and residents. Small group discussions following the IAT completion can allow participants to share their insights with others, make commitments to be aware of their behaviors, and seek to learn more about implicit biases. Institutions should use the results from IATs in combination with other data and exercises to help team members reflect upon and address their own biases.

UME and GME programs should work to longitudinally integrate curriculum on health equity, social determinants of health (SDOH), and cultural competence using an anti-racism lens. They should also identify these courses as core

components of the curriculum. As mentioned above, program directors and teaching faculty should find ways to integrate these topics during lectures throughout the core medical curriculum so that learners identify their professional responsibilities to their colleagues, patients, and community. For example, in a lecture on hypertension for internal medicine residents, the teaching faculty should critically analyze existing racial disparities in hypertension and the underlying social forces of racism, stress, and trauma, which are vital contributors to this pathology among non-Hispanic Black people in the United States.[26] They should also explore the lack of a biological basis for racial categories. These opportunities to address structural factors contributing to disease are ubiquitous throughout all specialties in medicine. Seeing and hearing about health equity, SDOH, and the impact of structural racism on communities of color and other historically marginalized groups in classroom didactics and clinical bedside teaching will result in a generation of physicians equipped to decrease the impact of microaggressions in clinical learning environments.

Mentorship is another crucial element in decreasing the burden and impact of microaggressions. While every student and trainee can benefit from targeted mentorship, a supportive relationship with a trusted mentor is critical for URM trainees who face microaggressions in clinical settings. Program directors should take a proactive role and assign chosen mentors to these trainees at the start of their training. Mentors should be knowledgeable about microaggressions, how to interrupt them, and should feel comfortable discussing this sensitive topic with their mentees. They should be able to provide them with support and resources as needed. Ideally, a trainee who encounters a microaggression will feel comfortable enough to reach out to their mentor, be able to debrief and discuss the situation, and feel equipped to take action. The trainee will then be able to find closure from the unpleasant exchange instead of experiencing a negative effect on their psychological well-being.

Finally, administrative policies should be established about training, professional development requirements, and expectations about workplace communication and interaction standards. Non-retaliation policies should also be put in place to support all team members who raise awareness about occurrences of microaggressions, which will create a culture of engagement and belonging.

Conclusion

We have outlined several evidence-based strategies and teaching frameworks that institutions and training programs can adopt to reduce the prevalence and impact of microaggressions on trainees from historically marginalized groups. Psychological safety for all trainees should be prioritized. Adequate resources and time should be set aside for faculty development. Training on microaggressions, health equity, and SDOH curricula should be woven into clinical training to broaden the perspective of all the residents. Targeted mentorship should be provided to residents who are most likely to be targets of microaggressions. Straightforward reporting mechanisms and transparent workplace policies about non-retaliation will ensure that these incidents are identified and addressed throughout the institution.

Case Review and Application

In the case presented at the beginning of the article, Isabel experiences overt discrimination and invalidation. It is implied that she is not qualified to be this patient's physician due to her accent and minoritized ethnicity. Learners often face this same sentiment in a more covert manner, or as a microaggression, when they are assumed to be a non-physician despite wearing an appropriate uniform and identification, clearly listing their position. In this context, they may be asked to perform duties far below their level of training because they are assumed to be non-physicians.

The role of the bystander— the senior resident, the attending, or a family member—is crucial in this case to 1) acknowledge what they witnessed, 2) respond with empathy rather than judgment, 3) inquire about the intentions of the comments, 4) identify how those comments impact the intern and bystander, and 5) provide education and dialogue about how these statements are harmful and that the workplace is one of inclusivity and mutual respect.

Conflicts of Interest

The authors declare they have no conflicts of interest.

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Author Affiliations

1. University of Central Florida College of Medicine, Orlando, FL
2. HCA Florida Osceola Hospital, Kissimmee, FL
3. Nemours Children's Hospital, Orlando, FL

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