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COMMENTARY AND PERSPECTIVE

Helping the learner to deal with microaggressions in the workplace: Individual, programmatic, and institutional-level responses

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Abstract

Microaggressions are frequently experienced by learners in the workplace and can create a hostile learning environment. Many faculty educators lack formal training in supporting their learners after incidents of microaggressions. Supervising faculty should be able to recognize and respond to microaggressions against trainees in the clinical environment. In this commentary, we will briefly review the definition of microaggressions, summarize the impact of microaggressions on trainees, provide a framework for managing microaggressions on an individual level when the patient offends the learner, and highlight strategies to mitigate microaggressions on a programmatic and institutional level.

KEYWORDS
emergency medicine, medical students, microaggressions, resident trainees

SCENARIO

> You are in the emergency department (ED) as a supervising attending. You have an Asian-American medical student, Student Doctor P, that you are working with that day. You both go into a patient room and introduce yourselves. The patient asks your student, "Where are you from?" Student Doctor P responds, "I am from California." The patient replies, "No, where are you really from?"

WHAT ARE MICROAGGRESSIONS?

Microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group."[1] There is a spectrum of microaggressions, ranging from microassaults, which are overt discriminatory statements, to microinvalidations that dismiss the feelings and experiential reality of a person.[2] Microaggressions can occur against any marginalized group including women, racial minorities, sexual minorities, people with disabilities, and religious minorities[3] and they are often manifestations of our biases.

In the clinical learning environment, trainees may face microaggressions from supervising physicians, clinical staff, colleagues, or patients. In fact, most trainees report experiencing at least one form of harassment or discrimination during their training.[4–6] These incidents may lead to negative self-perception and can impede learning, engagement, and self-belonging in academic communities through increased stress and emotional harm.[7–9] They may also distract the learner by taking cognitive time away from other important

tasks.[10,11] Moreover, microaggressions committed against trainees early in their professional identity formation may have a larger negative effect than later in their career.[3]

Many supervising faculty lack formal training in managing microaggressions and mitigating their effects on the learner. Unlike overt forms of workplace violence (e.g., physical assault, verbal outburst of racial slurs), microaggressions may be more difficult to recognize or easily dismissed as harassment. Moreover, the social struggles of various racial groups as highlighted in recent months across the United States highlight the importance of this topic and need for additional training of faculty and trainees.[12] When the perpetrator is the patient (very common in the health care setting),[2] faculty may struggle with whether and how to directly address the incident with the patient, particularly when the learner appears to be distressed or when the learner does not feel safe to discuss or show distress. In their role as supervising faculty physicians, they have a dual obligation to maintain a therapeutic alliance with the patient and foster a positive learning environment for their learner. However, when faculty do not address microaggressions, this constitutes harm to the learner, because it may convey permission of such bias.[13] In the next section, we provide a framework to address microaggressions when the patient offends the learner, scripts for faculty to assess how best to support a learner after an event, and programmatic or institutional ways to change community culture. We hope that these tools will mitigate the negative impact of microaggression on trainees in an increasingly complex clinical environment.

INDIVIDUAL RESPONSES TO MICROAGGRESSIONS

To respond effectively to microaggressions requires preparation and practice, like any other communication skill. There are multiple ways to manage microaggressions in the clinical setting.[2] One framework for addressing microaggressions includes: (1) set the stage, (2) name the behavior, (3) ally with the learner, (4) refocus on patient health, and (5) debrief after the interaction.

- **Set the stage for the possibility of microaggression on shift:** Particularly useful for an early learner or a first ED shift, introduce the idea of microaggressions before events occur. Trainees may feel embarrassed to discuss mistreatment, and thus it requires the educator to initiate the conversation.[3,13] Wheeler et al. suggest a script that introduces the concept of microaggression:

  a. "*I believe that to learn and care for patients to the best of our abilities, we all need to feel comfortable and supported in our work environments. I wish that expressions of bias never occurred; unfortunately, they do. Patients and families may say things that reveal their biases, and sometimes I myself may be the source. I want to know when you are not feeling comfortable or supported. I hope you will teach me as I teach you.*"[13]

Moreover, the educator can ask open-ended questions regarding how each team member would like to respond in the event that a microaggression occurs. Some trainees prefer to confront the patient themselves, while others might appreciate a senior member of the team to lead the response.

- **Name the behavior:** When a faculty member witnesses the microaggression, he/she should name the microaggression, so that both the learner and the patient have a context for the conversation. It is important for the learner to observe that the faculty has recognized the microaggression. This may be accomplished by paraphrasing the behavior back to the patient.[13]
  a. "*I think you were trying to compliment Student Doctor P by asking him about his background. As he stated he is from California.*"
  b. "*I heard you call Dr. S a nurse. She is in fact your doctor, who will be leading your patient care today.*"
- **Ally with the learner**: When the patient makes a derogatory comment to the learner, the faculty member can ally with the learner and emphasize his/her importance to the care team.
  a. *"Mr. P is a student doctor who is part of the team caring for you today, along with me, Dr. C, and your nurse, M."*
- **Refocus on patient health**: Redirect the conversation to prioritize patient care and safety.[3]
  a. *"I am here to focus on your health today."*
  b. *"We are concerned about your pain and let's discuss how we might be able to help address your concerns."*
- **Debrief after the interaction**: Faculty should make time to debrief with the learner as soon as possible after a microaggression, specifically focusing on one's emotions and reactions to the event.[13] Examples of how to initiate the conversation include:

  a. *"When I saw X, it made me feel Y."*
  b. *"How did others feel during the interaction?"*
  c. *"That was a really tough conversation. I feel mentally drained. How are you feeling?"*

The debrief session should also touch on aspects of the interaction that went well and aspects that could be improved upon on in the future. This discussion may lessen the trainee's distress and mitigate the negative effects of the microaggression.[3]

When these tactics fail to mitigate the microaggression or the situation escalates, the trainee may need to be removed from the interaction.[3] In addition, if a patient is critically ill or unstable, then the microaggression may have to be addressed at another time or not be addressed with the patient at all.[3,13] If the learner is removed from the clinical environment, obtain his/her perspective on reengaging in the patient's care and develop a plan together. Junior learners may not be able to effectively reengage with the patient or reengagement may be harmful to their personal development. Senior-level learners, however, should learn to reengage with the patient as they will need this critical skill to be an independent provider.

PROGRAMMATIC AND INSTITUTIONAL RESPONSES TO MICROAGGRESSIONS

There is a paucity of literature describing successful programmatic and institutional interventions on managing microaggressions in the clinical learning environment.[3,14] Programmatic and institutional interventions must address the multiple sources of microaggressions, including faculty, staff, patients, and peer trainees. Based on these limited data and our own experiences with trainees, we propose the following interventions.

- **Develop institutional-level tracking of trainee mistreatment**: Institutional reporting mechanisms are important to track and manage learner mistreatment. Identifying the perpetrator involved in the incident is crucial for implementing the appropriate changes on an individual, programmatic, or institutional level. Otherwise, the information collected on the Association of American Medical Colleges Graduation Questionnaire (GQ) or the Accreditation Council for Graduate Medical Education Resident/Fellow and Faculty Surveys are often too general to guide specific interventions. Mustapha et al.[15] at the University of Minnesota created a modified version of the GQ mistreatment questions, which includes harassment, discrimination, and shaming, to asses both the prevalence and the sources of microaggression among resident and fellow trainees. The University of California, San Francisco, implemented both confidential and nonconfidential mechanisms for reporting that is managed by the university's Office for the Prevention of Harassment and Discrimination.[16] Developing and implementing more specific surveys and reporting mechanisms help to track prevalence and sources of microaggression to guide targeted interventions.
- **Train faculty to recognize and respond to microaggressions:** Faculty who supervise trainees need to be able to recognize and manage microaggressions in the clinical environment as well as report them when appropriate. Workshops for faculty and/or trainees that include small-group discussions and role play have been shown to improve knowledge about microaggressions and confidence in responding to and reducing microaggressions in the clinical setting.[3,14] Additionally, simulation may emerge as another tool to teach and practice conversations in managing microaggressions in the clinical environment.[17] There is an upcoming session on using simulation in diversity, equity, and inclusion training at an upcoming national scientific assembly meeting for EM.[18]
- **Promote diversity in leadership**: Increasing diversity and inclusion of traditionally underrepresented groups in academic medicine helps to promote a variety of perspectives and create environments that are welcoming to all.[3] The number of underrepresented minorities and women in leadership positions is low, and as academic rank increases, these groups represent a smaller proportion of professors.[19,20] It is also easier for marginalized groups to recognize microaggressions than nonmarginalized groups. For example, a study by Periyakoil et al.[21] showed that women were much better at recognizing gender microaggression than men. Promoting diversity in leadership positions might improve recognition of microaggression that would lead to implementation of institutional policies and culture change.

CONCLUSION

Trainees may experience microaggressions in the clinical learning environment. Supervising faculty need to recognize and respond effectively to these incidents to mitigate their effects on the professional identity of learners. Individual faculty who witness microaggression may respond by naming the behavior, allying with the learner as part of the treatment team, and refocusing on the patient's health needs. We highlight the importance of implementing programmatic and institutional-level initiatives to track incidents of trainee mistreatment, promoting diverse faculty and leaders who may be better able to recognize and respond to microaggressions, and fostering a safe clinical learning environment for all learners.

CONFLICT OF INTEREST

The authors have no potential conflicts to disclose.

AUTHOR CONTRIBUTIONS

Danielle T. Miller: drafting manuscript, critical revision of the manuscript. Esther H. Chen: drafting manuscript, critical revision of the manuscript.

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