



Professionalism: microaggression in the healthcare setting

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Purpose of review

Microaggressions are daily commonplace, subtle behaviors and attitudes toward others that arise from conscious or unconscious bias. Not only can microaggressions affect one's access to power, resources, and opportunity, but they could also contribute to the persistent disparities faced by marginalized groups among healthcare professionals as well as patients.

Recent findings

Physicians, especially those in perioperative specialties, commonly have distress during their medical training. Workplace mistreatment, such as discrimination, has been commonly reported by residents across multiple specialties. Microaggressions also impact patient care as they can influence decisions of medical professionals toward a person or group of people.

Summary

This review offers education on the correlation of microaggression and unconscious bias to health disparities, provides tools to address microaggressions as a bystander, and outlines processes for institutional improvement.

Keywords

bystander training, health disparities, microaggression, professionalism, unconscious bias

INTRODUCTION

The inability to talk about race, racism, and structural racism led to the creation of the term microaggressions. Dr Chester M. Pierce, an African-American psychiatrist, coined this term in the 1970s to enable this dialogue around harm caused to nondominant groups. Microaggressions refer to 'commonplace behavioral indignities whether intentional or unintentional communicating hostile, derogatory or negative attitudes toward marginalized groups,' which can be found historically throughout man's existence [1]. Not only can microaggressions influence one's access to power, resources, and opportunity, but it could also contribute to the persistent disparities faced by marginalized groups among healthcare professionals as well as patients. Dr Derald Wing Sue and other psychologists have further developed a classification system to 'help people of color understand what is going on and perhaps to educate white people as well' in order to amplify the significance of this concept [2]. The reality of these experiences has galvanized the institutional movement for self-education and improvement, especially since microaggressions have stemmed historically from race relations in the United States over the past few centuries. What is understated is how these microaggressions have

been rooted in longstanding implicit and explicit behaviors and linked to health disparities. Recently the movement to increase diversity, equity, and inclusion processes has been shown to be both fiscally as well as morally beneficial to our profession and society [3]. This review offers education, processes for improvement, and a road map to begin the monumental task of creating what Martin Luther King Jr. had famously called the Beloved Community – one based on justice, equal opportunity, and

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KEY POINTS

- Microaggressions are categorized into three groups: microassaults, microinsults, and microinvalidations.
- Microaggressions may play a role in increasing the morbidity and mortality observed among certain racial minority groups as well as in people of low socioeconomic status.
- Harmful effects of microaggressions on healthcare providers, such as low quality of life and job dissatisfaction, have been associated with suboptimal care practices, major medical and medication errors, and decreased patient satisfaction with medical care.
- The strategies for addressing microaggressions include engaging institutions further in equity, encouraging everyone to take action as an upstander, and creating institutional accountability.

positive regard for one’s fellow people regardless of race, color, or creed.

MICROAGGRESSIONS: EXAMPLES IN HEALTHCARE

Microaggressions are categorized into three groups: microassaults, microinsults, and microinvalidations [4]. Each subgroup entails a form of general disrespect, devaluation, prejudice, and exclusion of the recipients as shown with examples seen in Table 1 [4,5]. Microassaults, unlike the other categories of microaggressions, are conscious biases or discriminatory verbal abuse or behaviors. Microinsults are typically unconscious messages that are insensitive and disparaging to a person’s racial identity or background. Microinvalidations are behaviors and statements that are meant to exclude, negate, and dismiss one’s personal feelings, thoughts, and experiences. In medicine, the idea that there is a meritocracy in promotions, salary, and academic success can be observed by internal audits. Ample evidence

has shown that white male physicians are given higher salaries and promoted to associate professors and professors more frequently than their female counterparts [6–8].

EFFECTS OF MICROAGGRESSIONS ON HEALTHCARE DISPARITIES

Multiple studies have proven healthcare disparities exist in the United States and that implicit bias and racism may play a role in increasing the morbidity and mortality observed among certain racial minority groups as well as in people of low socioeconomic status [9,10]. Pascoe and Richman’s review article found that perceived discrimination is a significant predictor of disparities in hypertension, cardiovascular disease, diabetes, and respiratory conditions for racial minorities [11]. The Institute of Medicine agrees that implicit bias, microaggression, prejudice, and stereotyping may play a role in the persistent healthcare disparities seen among marginalized groups. They agree recruiting more physicians of color from underrepresented communities could help reduce these disparities [12]. However, the recruitment and retention of physicians of color can be challenging when there is a constant lack of inclusivity and equitable representation, particularly in academic medicine. As previously mentioned, microaggressions are daily commonplace, subtle behaviors and attitudes toward others that arise from conscious or unconscious bias. Even though microaggressions are usually unconscious, they still impact the understanding, actions, and decisions of medical professionals toward a person or group of people. For example, in surgical procedures such as Cesarean sections in which there is a consensus that neuraxial blocks are preferred, black patients (adjusted odds ratio (aOR) = 1.7; 95% CI: 1.5–1.8; $P < 0.001$) and Hispanic patients (aOR = 1.1; 95% CI: 1.0–1.3; $P = 0.02$) remain more likely to receive general anesthesia with increased morbidity and mortality [13].

Table 1. Types of microaggressions with examples

Types of Microaggressions	Examples
Microassaults (Discriminatory verbal abuse)	‘Stop acting like an angry Black Woman’ ‘Why can’t you people ever listen’ ‘Why do I get a dumb Black Nurse’ [5]
Microinsults (Insensitive and disparaging comments)	‘You are a doctor? You look like a teenager’ Referring to minority residents or medical students as ‘those people’...obtained their current position because of ‘affirmative action’ [4]
Microinvalidations (Dismissive and exclusion practices)	During the ‘Black Lives Matter’ movement, some people came with ‘All Lives Matter,’ and ‘White Lives Matter’ to invalidate the feelings of a large group of people who have been disproportionately discriminated against by some law enforcement officers.

There are several research studies that have shown the detrimental effects of racial microaggression in the healthcare setting. In a study using an ethnographic framework to evaluate a group of obstetric patients, Smith-Oka discovered a new form of microaggression in which he termed *corporeal microaggressions*. The term describes the imposed values and hostile treatment of marginalized pregnant women by physicians who make degrading comments about their lifestyles. As an example, the author describes sterilization efforts in obstetrics that target single mothers and low-income minority women [14]. Another example of healthcare inequities can be seen among American Indian/Alaska Native communities (AIAN), who have higher rates of medical problems such as diabetes, cardiovascular disease, and mental health issues [15]. According to the National Healthcare Quality and Disparities Report, AIAN patients received worse healthcare than white Americans on approximately one out of three quality care indicators [16]. Some of these disparities may be a result of microaggressions experienced by the patient from their healthcare provider. In a study by Walls *et al.* survey interviews were performed on type 2 diabetic patients in two American Indian reservation communities. Over 30% of patients reported experiencing a microaggression in interactions with medical providers, and this correlated with self-reported history of heart attack, worse depressive symptoms, and prior year hospitalization [15]. This is a prime example of the importance of having a good provider-patient relationship, which can help improve patient adherence with medical advice and treatment protocols. When a healthcare provider commits a microaggression, the comfort and trust a patient may feel with the provider are likely to become damaged rendering the visit a source of stress and anxiety for the patient. Thus, it is important that all medical providers assess their unconscious biases and practice self-reflection and intentional actions in order to achieve high quality and culturally sensitive care.

UNCONSCIOUS BIAS ACROSS HEALTH DISPARITIES

Even though it is well known that health outcomes differ by race and ethnicity, these factors have been falsely attributed to be the main cause of health disparities rather than the unequally distributed stressors that align with social determinants of health. A few studies have evaluated the correlation of these social factors, including unconscious bias, to healthcare disparities. Recent research on race and postoperative outcomes has shown increased rates of surgical mortality among marginalized

groups and a decreased likelihood of receiving surgery compared to white patients [17]. Green *et al.* surveyed and implemented the Implicit Association Test (IAT) to 287 residents across four academic medical centers in Boston and Atlanta. The study revealed there was not only implicit bias favoring white patients (mean IAT score, 0.36 [$P < 0.001$]) but also unconscious perception of black patients as less cooperative with medical procedures (mean IAT score, 0.22 [$P < 0.001$]) [18]. Furthermore, the physicians' likelihood of treating white patients and not administering thrombolytic therapy to black patients increased ($P = 0.009$) as their pro-white implicit bias increased. Several studies have also demonstrated disparities across pain management among racial and ethnic minorities. These findings report that physicians are less likely to prescribe opioids or perform regional blockade to black and Latinx patients when compared to white patients [19–23].

DATA ON HARMFUL EFFECTS OF MICROAGGRESSION ON HEALTHCARE PROVIDERS

Physicians, especially those in perioperative specialties, commonly have distress during their medical training [24,25[■]]. Factors such as depression, low quality of life, job dissatisfaction, and physician burnout have been associated with suboptimal care practices, major medical and medication errors, and decreased patient satisfaction with medical care [24]. Workplace mistreatment, such as discrimination, can create a harsh work environment that can lead to burnout and suicidality [25[■],26]. In 2018, a cross-sectional national survey of general surgery residents ($n = 7409$) demonstrated that 31.9% reported discrimination based on their self-identified gender and 16.6% reported racial discrimination. Furthermore, patients and their families were the highest source for racial discrimination as reported by 47.4% of residents and gender discrimination as reported by 43.6% of residents [25[■]].

Medicine has historically been a field where the power dynamic has shifted in favor of the healthcare provider when compared to the patient. However, this authority can be reversed rendering the medical provider vulnerable when confronted with discrimination [27]. When patients refuse care based on the treating physician's ethnic or racial background, this mistreatment can be harmful for the doctor involved and can raise legal, ethical, and clinical issues [28]. According to Title VII of the 1964 Civil Rights Act, all employees of healthcare facilities have the right to a work environment free from discrimination based on gender, race, ethnicity,

religion, and national origin [28,29]. Residents experiencing mistreatment from patients require attendings to become upstanders as described below and have the responsibility, as a mentor and teacher, to perform in a manner that will minimize the harmful effects of blatant racism [30].

INTERVENTIONS FOR MICROAGGRESSIONS

Years of empirical research on microaggression theory have established that it results in adverse mental and physical health and creates toxic environments within education, healthcare, and workplaces broadly [31,32]. Although most contributions have focused on the manifestation and impact of microaggressions, emerging literature is also making strides in developing strategies to address such occurrences. These interventions are designed to engage institutions further in equity, to encourage everyone to take action, and to create institutional accountability. By employing these strategies collectively, there is a real possibility to uproot microaggressions, address power differentials embedded in hierarchical systems, and ultimately shift the culture of academic medicine and medical education toward inclusion.

Institutional engagement – lead with diversity, equity, and inclusion

Across medical education and healthcare, institutions have committed to diversity in organizational structure with dedicated roles and departments, diversity-themed programming, inclusive communications and marketing, and codes of conduct. Wheeler and colleagues outlined 12 tips for responding to microaggressions and overt discrimination, the first being to ‘establish a culture of openness and respect upfront.’ In addition to expressing commitments to diversity, there is also a need to establish a culture where critical dialogues on diversity themes, including microaggressions, can occur [33]. Given the overwhelming evidence for the presence of discrimination and microaggressions in medical education and healthcare, change must begin with an admission that such events, unfortunately, do occur [34]. Engaging in diversity training that includes information and skills-based strategies to promote equity and inclusion is an important start. Also, individuals holding leadership, managerial, or supervisory positions can further equity by leading with diversity, whether at the start of a new cohort, the beginning of a new rotation of learners, or during patient and family encounters. Leading with such commitments can foster important dialogues and create space to

address diversity themes and issues such as microaggressions when they arise without hesitation.

Bystander to upstander – develop skills to disrupt microaggressions

Microaggression educational efforts are often crafted in diversity training and workshops to provide foundational information, confirm the validity of such everyday experiences, and raise awareness for audience members to see and hear microaggressions when they occur. Current literature on microaggression interventions has focused on the target of microaggressions in developing communications strategies to respond to such indignities although maintaining professional decorum [35,36]. Although there will always be a place for supporting the resilience of those who are the targets of microaggressions, doing so in isolation may send an indirect message that individuals who are the targets of microaggressions are solely responsible for addressing them. This dynamic reinforces systems of hierarchy and power for those who commit microaggressions and absolves individuals who witness such violations from any responsibility to intervene or advocate. Such traditional approaches might be considered a missed occasion to plant seeds of change.

There is an important opportunity for those who witness microaggressions to take action. Social psychology research on the bystander effect indicates that other people’s presence reduces the likelihood that an individual will help, especially when situations are deemed to be nonurgent [37]. However, knowing the harm that microaggressions cause can help people push back against the inclination to minimize these events. In the face of microaggressions, one must transition from being a bystander who stands on the sidelines to an ‘upstander’ who takes action in the spirit of true allyship. Upstanders can apply the same interventions or techniques that the literature has offered to the targets of microaggressions [33,38,39]. Such interventions include direct and indirect strategies, and preferred interventions are outlined below in Table 2. Along the journey to becoming an upstander and with consideration to skill and interpersonal style, directly interrupting microaggressions may feel challenging at first but requires practice similar to any other clinical skill development. Indirect strategies also exist as a way to disrupt microaggressions, but these have limitations on the ability to have a direct dialogue about the incident and underlying concerns. On the other hand, direct strategies are designed to invite conversation to explore the microaggression, increase perspective raising, and provide a pathway for feedback.

Table 2. Examples of indirect and direct strategies to address microaggressions

Indirect Strategies	Direct Strategies
Redirect Change the subject or shift attention away from the target.	Reflect Back <i>'I heard you say ____, can you explain what you mean by ____.'</i>
Uplift Elevate the target by countering the microaggression with affirmation, <i>'You are partnered with an amazing provider and are so fortunate to have them taking care of you.'</i>	Communicate Impact <i>'Using words like __ makes me feel uncomfortable.'</i>
Besting [39] Use affirming counter-narratives to oppose microaggressions. <i>'Historically Black Colleges and Universities (HBCUs) matriculate the highest percentage of Black doctors.'</i>	Raise Awareness <i>'I believe a more inclusive term is ____.'</i>
	Check-In (with the person who committed a microaggression): <i>'I've been reflecting on the conversation from our team meeting yesterday. Can we find some time to check-in?'</i>
	Reaffirm Boundaries <i>'We do not tolerate that kind of language, and I ask that everyone speak with respect.'</i>

Presently, the Association of American Medical Colleges definition of mistreatment is a 'behavior that shows disrespect for the dignity of others and unreasonably interferes with the learning process.' It can take the form of physical punishment, sexual harassment, psychological cruelty, or discrimination based on race, religion, ethnicity, gender, age, or sexual orientation [34]. A 2020 study examined the prevalence of medical student mistreatment by sex, race/ethnicity, and sexual orientation and reported that 'female, under-represented in medicine, Asian, multiracial, and LGBT students seem to bear a disproportionate burden of the mistreatment' within medical schools [34]. Although the current definition of mistreatment does name 'discrimination' based on protected categories, the omission of microaggressions as a form of mistreatment may result in under-reporting, thus inhibiting the ability to address such harm.

CONCLUSION

Institutional policy and codes of conduct should include pathways to documenting microaggressions and being transparent about the frequency of such events and approaches to addressing them. Furthermore, institutions must also develop systems of accountability to help mitigate such occurrences across student, resident, patient, and faculty roles. Confronting microaggressions is a critical step in the process of mitigating racism as well as structural racism and achieving the aspirational goal of reducing health disparities.

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- of special interest
- of outstanding interest

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