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TWELVE TIPS

Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner

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ABSTRACT

Microaggressions and expressions of overt discrimination negatively affect the experience of medical trainees at all levels. Mistreatment of trainees, including abusive and discriminatory behavior by patients and families, occurs commonly and is receiving increased attention in both the medical literature and popular press. Heightened awareness of the problem has sparked a call to engage in substantive conversations about bias in health professions education. The emphasis on direct observation in medical education makes the bedside a common setting for educators to witness these behaviors firsthand. Many educators are committed to developing a positive climate for learners but lack the training and skills to facilitate discussions about discrimination. As a result, these difficult but important conversations may not occur. The authors present a three-phase approach to responding to microaggressions and discrimination toward trainees from patients, and offer a communication toolkit that frontline medical educators can use in their daily practice.

Introduction

The following scenarios, adapted from real-life clinical encounters, will be used to illustrate potential applications of the communication toolkit described below.

Scenario 1:

A female trainee, Dr. W, has cared for a male inpatient, Mr. A, for several days and has introduced herself as "Dr. W" multiple times. On rounds when the team comes in, the patient asks her, "Nurse – can you get me another pillow?"

Scenario 2:

An Asian-American trainee in clinic meets a new patient, who identifies as white.

Dr. P: "I'm Dr. P. I'll be your regular doctor."

Ms. B: "Great to meet you, doc. Where are you from?"

Dr. P: "Houston."

Ms. B: "No, I mean where are you from from?"

Dr. P: "Oh … you mean my family? My grandparents are from Korea."

Ms. B: "Your English is outstanding."

Scenario 3:

A medical team comprised of a senior doctor, two junior doctors, and two medical students enters the room of a patient, Mr. S, admitted for an exacerbation of chronic obstructive pulmonary disease (COPD). Mr. S, who identifies as white, continues to require supplemental oxygen despite completing treatment for the exacerbation. The team previously recommended that he use supplemental oxygen at home; however, he has declined home oxygen.

Junior doctor: "Mr. S, your oxygen levels are still a bit low even after treatment. As we mentioned, given your COPD, your lungs would benefit from oxygen when you go home."

Mr. S: "I already told you I don't want it."

Senior doctor: "Thanks. It's important that we hear that again. Please tell us why."

Mr. S: "It's simple. I live in a bad part of town, and there are [racial epithet]s all over the place. If I go home with oxygen, these [racial epithet]s will steal the tanks."

Mistreatment of medical trainees is a common occurrence and can contribute to burnout, moral distress, and other physical and psychological harms (Wolf et al. 1991; Jain 2013; Montenegro 2016; Paul-Emile et al. 2016). Most medical trainees report experiencing at least one form of harassment or discrimination during their training (Fnais et al. 2014). Examples of mistreatment include overt racism, sexism, and other expressions of bias, as well as the subtler slights known as microaggressions, defined as "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" (Sue et al. 2007).

The impact of microaggressions and other discrimination on medical trainees, including abusive and discriminatory behavior by patients and their families, is receiving increased attention in both the medical literature and popular press (Chen 2013; Lucey et al. 2016; Okwerekwu 2016a; Olayiwola 2016; Whitgob et al. 2016; Reiff-Pasarew 2017; Wear et al. 2017). A meta-analysis of the prevalence of trainee mistreatment found patients and families to be a common source (Fnais et al. 2014). Despite powerful calls to action to address bias affecting trainees in health professions education, explicit guidance for educators seeking to navigate these challenging situations is lacking (Whitgob et al. 2016). Responding to microaggressions from patients is especially difficult, as providers must address the offensive behavior while preserving a therapeutic alliance and upholding the ethical principles of beneficence, nonmaleficence, and patient autonomy. Often, these responsibilities may seem at odds. Without specific training and skills to

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address mistreatment, educators may feel ill-equipped to facilitate conversations with their trainees. Indeed, this paper emerged from our own feelings of discomfort when approaching these troubling encounters.

Based on a review of the literature and our shared experiences (we have witnessed microaggressions toward trainees and faced similar mistreatment during our own training), we propose twelve tips for addressing microaggressions and other expressions of bias from patients and families experienced by trainees. We do not intend to imply that patients and their families are alone in committing these acts of discrimination; indeed, multiple studies have identified physicians as the most common source of learner mistreatment (Crutcher et al. 2011; Fnais et al. 2014; Mavis et al. 2014). Many of the tips we describe may also apply to expressions of bias from senior physicians; however, the presence of a powerful hierarchy and threat of reprisal (e.g. evaluations, letters of recommendation) make such interactions additionally complex (Mensah 2017). Moreover, while we hope for respectful interactions between colleagues, such encounters do not involve the same ethical considerations found in the patient–provider relationship. We have chosen to limit the scope of this paper accordingly.

With renewed emphasis on bedside teaching and direct observation in medical education, the bedside may be the most consistent location for faculty to witness learner mistreatment firsthand (Ramani 2003; Kogan et al. 2009; Qureshi and Maxwell 2012; Monash et al. 2017). In this article, we provide frontline educators with a three-phase approach, including a toolkit of communication strategies to use during these uncomfortable and challenging teaching encounters. We use the scenarios described above to demonstrate ways in which the tools may be applied. There is no single "right" method, as each educator, trainee, and patient brings a different set of experiences and perspectives to the same interaction. Yet, with deliberate practice, reflection, and a healthy dose of self-regulation, educators may develop increased comfort in these situations. We hope this paper will empower faculty to address these difficult topics directly.

Setting the stage

Tip 1

Establish a culture of openness and respect up front

To facilitate effective dialog with trainees about bias, one must first establish a safe and positive learning environment (Whitgob et al. 2016). Facing a sizable power differential, trainees may not feel comfortable sharing their experiences about mistreatment with senior members of medical teams (Montenegro 2016). Supervising physicians are often unaware of the power they wield in defining the learning climate; they should explicitly set the expectation that all participants in the health system – including staff, patients, and trainees – will be treated with respect. To set the tone, educators may acknowledge their own fallibility and invite learners to provide constructive feedback.

> Senior physician, possible introductory statement to new learners:
>
> "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."

In the same way that a positive learning environment allows open dialog between members of the medical team, a strong therapeutic alliance with the patient sets the stage for effective patient-centered inquiry and discussion. A patient–provider relationship built upon respect, trust, and reciprocal exchange of information can lead to improved rapport, satisfaction, and openness to negotiation for both parties (Goold and Lipkin 1999; Fortin et al. 2012). If a patient commits a microaggression, a preexisting positive relationship between patient and provider can strengthen the communication strategies described in this text.

Tip 2

Be prepared to recognize microaggressions and discrimination

Educators must watch for potentially hurtful discriminatory comments and behaviors. Microaggressions and discrimination may disproportionately affect trainees from underrepresented minority groups, including those related to race, ethnicity, gender, sexual orientation, and ability (Richardson et al. 1997; Montenegro 2016; Ulloa et al. 2016). Whereas some behaviors are obvious (e.g. use of racial epithets), many situations are ambiguous, open to interpretation, and challenging to recognize. Drawing upon personal and cultural experiences, each individual in the room may interpret the same encounter differently. If the supervising physician has any question about trainee perception of a particular encounter, further inquiry can lead to greater understanding. Even if trainees appear unaffected, asking about possible discomfort can help create a safe environment for future discussion.

> Senior physician, possible observation during inpatient rounds:
>
> "I felt uncomfortable when Mr. J spoke only to the men on our team. I wonder if anyone else noticed that."

Responding in the moment: a toolkit

Possibly the most challenging aspect of confronting microaggressions and discrimination is that it requires what Schon calls "reflection-in-action" (Schon 1987): the complex act of processing and potentially responding to these unexpected comments in real time. Tips 3–9 provide educators with a communication toolkit to deploy in the moment. Adopting these tools requires preparation, rehearsal, and retrospective reflection. In contrast to "reflection-in-action," retrospective reflection enables us to consider how our behaviors influenced prior interactions and how specific tools might affect similar encounters in the future. The tools we present are not designed to be used in sequence, but as the situation dictates. Certain tools will work better in

certain situations. For example, after hearing a racial epithet, "sharing your own response to communicate impact" (Tip 6) might identify the statement as problematic without alienating the patient or validating the remark, whereas it may feel inappropriate to "repeat the patient's statement and allow time for reflection" (Tip 5). Lastly, we view this toolkit as a starting point and hope that our readers will use deliberate practice and retrospective reflection to develop new techniques of their own.

Tip 3

Determine whether to respond at the bedside

Upon identifying an objectionable patient comment or behavior, educators must determine whether to respond immediately or during a subsequent interaction. An immediate response may allow the supervising physician to modify a specific behavior, role-model patient communication techniques, or initiate a dialog to elucidate the patient's perspective.

Assess the situation

Not all expressions of bias can or should be addressed in the moment. When a patient's condition is unstable, clinicians must overlook discriminatory comments and behaviors (Whitgob et al. 2016). Additionally, when patients' medical or psychological problems limit their ability to interact appropriately, bedside conversation may be unhelpful. Other circumstances may interfere with an immediate response, including time pressure, patient discomfort, or an educator's inability to recognize the microaggression. In contrast, some particularly severe or offensive behaviors may demand an immediate response.

Check your own reaction…

Before responding to an expression of bias, educators should first assess their own reactions (for example, how did you feel when reading the scenarios at the beginning of the text?). Threats to physician integrity and self-esteem may elicit strong emotions (Smith and Zimny 1988) and can negatively affect the encounter. The threat or expression of prejudice can trigger a psychological and physiological stress response (Sawyer et al. 2012), potentially activate the body's "fight, flight, or freeze" system of defense (Maack et al. 2015), and impair critical thinking (Lucey et al. 2017).

With activation of the sympathetic nervous system, reflection-in-action becomes more difficult. Negative personal emotions may trigger impulses to avoid or accommodate the behavior (e.g. by apologizing or laughing), which may signal implicit acceptance. Negative emotions can also lead to counterproductive arguments that will, at best, detract from the patient–provider relationship, and worse, escalate the conflict (Halpern 2007). Abrupt, emotionally charged responses may also reinforce the hierarchy between patient and provider. For instance, imagine a provider responding to Scenario 1, saying, "Come on, Mr. A! She's obviously not your nurse, she's your doctor!" Such a response would convey the correct information but might also discourage the patient from engaging in future dialog. By recognizing negative emotions, educators may be able to moderate their negative appraisals and respond instead with one of the tips described below.

…but don't allow your own discomfort to hold you back

Lacking formal training, many faculty feel uncomfortable facilitating conversations about microaggressions and avoid these difficult topics altogether (Murray-García et al. 2014). Unfortunately, silence in the face of bias or mistreatment forces trainees to confront the situation alone. Worse yet, an educator's inaction may signal tacit acceptance (Okwerekwu 2016a; Acosta and Ackerman-Barger 2017): "silence in the face of injustice not only kills any space for productive conversations, but also allows cancerous ideas to grow" (Okwerekwu 2016b). The educator need not have all the answers but must prepare to "leave the relative comfort of abstraction, and instead teach and practice *fearlessness*" (Wear et al. 2017). This courage starts with acknowledgement of the observed mistreatment, the first step toward allyship, dialog, and positive change in the institutional climate.

Tip 4

Attempt unconditional positive regard

Although microaggressions are hurtful, it is important to remember that patients often do not intend them as such (e.g. scenario 2). By maintaining unconditional positive regard for their patients, providers may be able to explore comments more objectively and avoid responding with negative emotion. A lack of immediate judgment may enable the patient and provider to maintain a therapeutic alliance, even if disagreement exists (Rogers 1961).

> Scenario 2, possible response:
>
> "It sounds like you intended to compliment Dr. P."

Tip 5

Repeat the patient's statement and allow time for reflection

Upon hearing an expression of bias, educators may choose to paraphrase the statement (Interrupting microaggressions … 2014) and repeat it back to the patient. Repetition can aid understanding while exploring the patient's beliefs and opinions nonjudgmentally; it also provides patients with an opportunity to modify their statements.

> Scenario 1, possible response:
>
> "Mr. A, what I heard was that you think this is one of your nurses. Is that correct?"

Tip 6

Share your own response to communicate impact

By describing their feelings or reactions, educators can communicate the effect of the behavior or words with minimal inference (Interrupting microaggressions … 2014).

Using "I" statements that focus on personal feelings rather than opinions represents a helpful way to share one's own perspective, minimizing judgmental valence (Davis 2018). One possible framework to employ is "when I noticed x, the impact on me was y."

Scenario 3, possible response:

"When I heard you use that term to describe people in your neighborhood, I felt uncomfortable."

Tip 7

Open a dialog to learn more about the patient's perspective

Exploring the patient's reasons for making a discriminatory comment by engaging in dialog with appreciative inquiry is an important skill for faculty and trainees to develop. Conversation can also provide opportunities for strengthening the therapeutic alliance, expressing empathy for the patient's difficulty without endorsing the bias, and giving corrective feedback.

Scenario 3, possible response:

"When we come back, we would like to hear more about some of the challenges you've faced living in your neighborhood. What you are describing sounds difficult. It's also hard for us to hear the words you used."

Tip 8

Use objective statements, when possible

While it is important to recognize and discuss the emotions triggered by expressions of bias, an emotion-laden response to a patient can backfire. Whitgob et al. (2016) have discussed "depersonalizing" the event by using low inference, objective statements. These can be used to identify and correct inappropriate behavior without inciting conflict. The suggestion to use objective statements may seem to contradict Tip 6 ("Share your own response to communicate impact"); however, the two tools are in fact complimentary. Describing one's own emotion is different that responding with emotion.

Scenario 1, possible response:

"Mr. A, may I clarify something? This member of your care team is not your nurse; she is the doctor who has coordinated all of your care in the hospital for the last three days."

Tip 9

Know when to walk away

Although patient–provider dialog about bias can have educational and therapeutic benefits, it is important for faculty and trainees to feel empowered to remove themselves from a situation if necessary. When a patient is clinically stable and requires no immediate attention, educators should establish clear boundaries with the patient, including specific behaviors that are unacceptable (Paul-Emile et al. 2016). It may also be useful to discuss accountability.

If a patient persists in discriminatory or abusive behavior despite objective, corrective statements, the provider can justifiably consider stepping away from the encounter. The provider should then make follow-up plans to ensure that the patient continues to receive appropriate care. In cases of particularly egregious behavior, one should consider alerting hospital officials, including risk management and disruptive behavior staff.

Learning from the encounter and preparing for next time

Tip 10

Debrief with learners outside the room

After an uncomfortable patient encounter, it is important to provide trainees with time for reflection and debriefing, in real time if possible. At a minimum, the educator should acknowledge what happened, to avoid learners' conclusions of implicit acceptance. When facing bias, supervising physicians may feel as uncomfortable as their learners. Acknowledgement of our own discomfort can help build a safe environment for discussion and personal reflection.

Scenario 2, possible self-disclosure in a debrief conversation:

"When I heard the patient ask you where you were from, I felt uncomfortable."

It is important to provide space for learners to reflect, regardless of whether they were the target of the microaggression. On inpatient teams of trainees, involving the entire group in the discussion can help deflect attention from any single group member. Educators should actively listen to the responses of the learners and validate their feelings.

"How did others feel during the encounter?"

Asking the group about similar past encounters is another way for the educator to demonstrate support and create space for discussion.

"We know that many women physicians are treated differently because of their gender. What have your experiences been?"

The educator may encourage trainees to consider how they might adjust their responses to future microaggressions. It is equally important for educators to reflect on their own actions. Retrospective evaluation of the encounter – and specific behaviors – is an element of deliberate practice that may prepare the educator to respond more effectively to future expressions of bias.

Tip 11

Practice saying the words

Like other challenging but crucial conversations in the health care setting, such as delivering bad news, responding to expressions of bias is a skill honed with repetition, self-reflection, and deliberate practice. In particular, it can be helpful to practice saying the exact words you might use in a given situation. We recommend imagining specific scenarios involving expressions of bias with learners and, using the tips described here, trying out words that you might say, rather than the exact responses we have offered

(Lemov et al. 2012). A trusted peer coach may be a helpful practice partner.

Tip 12

Seek out training opportunities that allow for discussion about race and discrimination

Racism, discrimination, and bias are major issues affecting many elements of health professions education, and positive culture change will require a comprehensive, multifaceted approach. Some institutions offer local structured training for faculty around privilege and discrimination. Formal training programs for communication have led to increased physician self-confidence in these skills (King and Hoppe 2013), and we urge interested educators to seek out these opportunities if available.

Conclusions

Microaggressions and discrimination from patients toward learners are common occurrences in clinical teaching encounters and negatively affect the experience and performance of health professions trainees. In order to create a safe, positive learning environment, medical educators must develop skills to address these challenging interactions. Here, we present a three-phase approach to responding to microaggressions and discrimination toward trainees from patients, and offer a communication toolkit that frontline medical educators can use in their daily practice. This paper is no substitute for the formal faculty development necessary to improve the dialog about microaggressions and discrimination in our training programs and academic health centers (Acosta and Ackerman-Barger 2017; Lucey et al. 2017). Moreover, while we have grounded these tips in theory and our own experiences, evaluating the tips more rigorously could validate the approach. A recently published curriculum showed that, using simulation training, junior doctors in the United States were able to increase their sense of preparedness to manage discriminatory comments during clinical encounters, although no specific communication tools were named in the paper (March et al. 2018). Ultimately, we hope that the specific phrases and actions provided in this toolkit, along with the processes of reflection-in-action and deliberate practice, will empower medical educators to speak up courageously in the face of microaggressions and discrimination and begin important conversations with their learners.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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