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Ashishkumar K. Parikh

Jessica R. Leschied
Henry Ford Health, jessicale@rad.hfh.edu

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MINISYMPOSIUM: DIVERSITY, EQUITY AND INCLUSION

Microaggressions in our daily workplace encounters: a barrier to achieving diversity and inclusion

Ashishkumar K. Parikh[1] · **Jessica R. Leschied**[2,3]

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Abstract
Originally coined in 1970 by Dr. Chester Pierce, the term "microaggression" encompasses any subtle insult or informal degradation of a member of any socially marginalized group. While incidents of blatant racism and sexism might be deterred by zero-tolerance policies in the workforce, microaggressions still plague our daily interactions with colleagues and patients alike. In this paper we define and categorize microaggressions using real-world examples, describe their repercussions and provide ways to appropriately respond to microaggressions on a personal and institutional level.

Keywords Diversity · Equity · Inclusion · Microaggression · Racism · Radiology · Sexism · Underrepresented minorities

Introduction

Note: The bulleted example statements are real-life comments received by radiologists at some point during their medical or radiology training.

In recent years, issues of diversity and inclusion have come to the forefront of our general culture as well as the internal culture of medical institutions. Diversity and inclusion are important in all realms of medicine but take on a special significance in specialties where women and racial and ethnic minorities are underrepresented. Radiology is one such field. The proportion of women radiologists has remained stagnant at 25% over the last decade [1], and radiologists from underrepresented minorities represent an even smaller proportion of our workforce at 6.5% [2]. While, thankfully, the instances of blatant and explicit racism and sexism are diminished in the workplace as a result of institutional zero-tolerance policies, educational efforts and a social climate demanding equal treatment for all, microaggressions still plague our daily interactions with colleagues and patients.

The term "microaggression" was originally coined in 1970 by psychiatrist Dr. Chester Pierce, who recognized the mental and physical effects of everyday verbal, behavioral and environmental insults toward African Americans that might not have intentional negative consequences yet quietly communicate disrespect, devaluation and negative attitudes to the recipient [3]. More recently, the term has been applied to any subtle snub or informal degradation of a member of any socially marginalized group including, but not limited to, women, LGBTQIA+ people (lesbian/gay/bisexual/transgender/questioning/intersex/asexual/+ [denoting anyone else not included]), underrepresented minorities, persons with a disability, and people living in poverty.

Four subtypes of microaggressions have been described based on the work by psychologist Dr. Derald Wing Sue [4]: microassaults, microinsults, microinvalidations and environmental microaggressions.

Microassaults

- "Look at that — a woman, I mean resident, that can think on her feet!"
- "Why is it that on *Grey's Anatomy* [medical television show] all of the residents are sleeping with their attendings but that doesn't happen in real life?" – male attending to female resident alone in the doctor lounge

✉ Ashishkumar K. Parikh
akpari2@emory.edu

[1] Department of Radiology, Children's Healthcare of Atlanta, Emory University School of Medicine, 1405 Clifton Road NE, Atlanta, GA 30322, USA

[2] Division of Pediatric Radiology, Department of Radiology, Henry Ford Health System, Detroit, MI, USA

[3] Division of Musculoskeletal Radiology, Department of Radiology, Henry Ford Health System, Detroit, MI, USA

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These are the most blatant of microaggressions and consist of explicit statements or actions intended to offend the recipient, based on or in fact motivated by racism or sexism. An example that we have all been privy to, or perhaps guilty of, is the telling of a racist or sexist joke.

Microinsults

- "It must be nice to get everything that you want based on how you look."
- Fellowship evaluation: "She is very bright and competent, but I wish she'd smile more often."

These are considered more subtle comments or actions that are not intended to be discriminatory but yet still convey a humiliating or demeaning undertone. Common nonverbal examples include women physicians being mistaken for a nurse or an underrepresented minority physician being mistaken for a non-medical role, merely because they do not fit the traditional image of a physician.

Microinvalidations

- "They are just harmless old men." – program director referring to male attendings who cannot remember names of the few women radiology residents in the program
- "Sometimes the girls just don't get along." – division director dismissing the interpersonal challenges within his division

These are comments intended to diminish a person's experience, thoughts or feelings. An example would be to assume that race and gender play no role in professional success, or to deny that race or ethnicity might contribute to unequal health outcomes among specific patient populations.

Environmental microaggressions

A fourth subtype of microaggression is that of the impact that one's environment or workplace climate and policies might have on the sense of belongingness or lack thereof, of a group of individuals. This has been termed "environmental microaggressions" [5]. Examples include hallways or libraries decorated with pictures of only white male radiologists, a lack of diversity in leadership positions in a department, inadequate family leave policies, lack of lactation support in a department or hospital, or inappropriate pronoun use during imaging encounters of members of the transgender/gender non-binary population [6]. The consequences of these policies or environments are that they create a culture of exclusion whereby individuals feel like they might not be welcome or are regarded as "other" or "unusual."

- "You're not our usual radiology applicant." – resident interview comment

Addressing microaggressions

Consequences of microaggressions can be detrimental to the physical and mental health of the recipient. Studies evaluating the effects of microaggressions on women and underrepresented minority medical professionals have linked microaggressions to the development of depression, anxiety and hypertension in the recipient, and to internal feelings of inadequacy, otherwise known as the imposter syndrome [7, 8]. Given that many of these factors can lead to increased burnout, delayed or blunted professional success, or, in the saddest of cases, individuals leaving the profession and taking their unique ideas and perspective with them, it is important that we address the cost of microaggressions and start educating ourselves, our colleagues and future radiologists about what microaggressions are and how to remove them from our vocabulary and mindset.

The first step in addressing microaggressions and their impact is to acknowledge that they exist [7]. Once one is aware, the response to microaggressions can vary depending upon whether the response is from an individual or part of the collective, i.e. the organization or institution. Many resources and evidence-based advice have been published in the literature on how to respond to or mitigate microaggressions at a personal level; however, fewer resources are dedicated to promoting effective ways to prevent or address microaggressions at an institutional level. In fact, and not entirely surprising, efforts to address systemic biases within American institutions have been met with stern resistance from our leaders at the highest level (Executive Order 13950, Combating race and sex stereotyping, Oct. 2020; though at the time of this writing, the current 46th President of the United States had reversed this order) [9].

Our own implicit biases directly correlate with the microaggressions we subconsciously communicate to our colleagues. Although acts of explicit bias have declined over the years, the implicit biases embedded in our society have not [10]. This has led to a focus on preventing microaggressions by addressing our own inherent biases because it is these biases that have fueled microaggressions within the workplace. Explicit bias has been shown to decrease as one ages or through multicultural training and workshops, but implicit bias remains unchanged [10]. How should institutions or departments address our inherent biases? It starts with leadership and commitment from the top with involvement of all stakeholders. Diversity and inclusion must

become a priority of institutional or departmental leadership rather than merely a compliance requirement. If made a priority, then the necessary allotment of resources should be provided [10]. This might include designated diversity champions or diversity–equity–inclusion committees within the department, with those involved given the appropriate funds and time to pursue efforts to the cause. Goals should be set with a realistic timeline for completion, and measurable outcomes are more successful in enacting change, as in "what gets measured, gets done." Metrics for recruitment, interviewing of candidates and retention of residents and staff could be considered.

Everyone within an organization should understand the negative psychological and physical toll of microaggressions upon victims. Self-administered questionnaires, such as the Implicit Association Test [11], can be useful tools to help individuals understand our inherent prejudices; however, the test is not without its flaws. It has demonstrated only modest test–retest reliability [12] and has been criticized for not actually contributing to a change in behavior [10].

Not every approach needs to be innovative; copying other examples of success should be encouraged. One example of an initiative to diminish microaggressions in the academic classroom and academic faculty workplace was outlined by Dr. Ron Berk, professor of biostatistics at Johns Hopkins University [13]. This strategy included planning regular meetings between the underrepresented groups and the deans and department chairs to maintain open dialogue and appointing diverse faculty members to all critical committees, including promotion, search, diversity, oversight, curriculum and others. Current and incoming faculty should be oriented to the existence of microaggressions and their impact on patients and colleagues from marginalized populations. Emphasis should be placed on how to recognize and respond to these insults and be an effective ally to victims of microaggressions [10]. Specific strategies laid out in the literature, with examples to follow, include making the "invisible" visible, disarming the microaggression, educating the offender and seeking external reinforcement or support [10].

Making the 'invisible' visible

Making the "invisible" visible brings the microaggresion to the forefront of the person's awareness. For instance, the only woman radiologist of an otherwise all-male radiology division who is consistently addressed by her first name during staff meetings or tumor boards while her male colleagues are referred to by their professional titles can respond by utilizing several tactics. One is to undermine the metacommunication by saying directly, "I would prefer that you refer to me as Dr. So-and-so." Another is to challenge the stereotype: "I believe I deserve the same recognition as my colleagues."

Disarming the microaggression

Disarming the microaggression serves to quickly deflect or disapprove of the behavior. For example, an African American male surgeon is recruited to a prestigious academic institution. Soon after the hiring, you hear a colleague telling another colleague that "he probably got the job because he is a diverse candidate and not because of his skill." To disarm this microaggression, you can express disagreement by stating to the offender, "I don't agree with what you just said." You can also firmly suggest that those kinds of demeaning statements are not welcome in your department or are against hospital code of conduct.

Educating the offender

Educating the offender serves several purposes: (1) allowing a bystander to share his/her/their experience and knowledge, (2) lowering the defense of the often unknowing offender by placing the focus on learning and improvement rather than on shame and (3) increasing awareness. In this scenario, a gender non-binary physician is asked by their male colleague to perform an endocavitary US on a woman seeking care from a female physician. The gender non-binary physician has an opportunity to educate their male colleague about their gender non-binary status and remind him that they do not identify as a woman, though they are happy to provide care to the patient if the patient prefers. This example can (and has) prompted a discussion on policy change for the department and has brought awareness to proper pronoun usage and inclusion of LGBTQIA+ providers.

Seeking external reinforcement or support

Seeking external reinforcement or support is important in mitigating the emotional or psychological effects that bias and microaggressions can have on individuals. It also serves to more aggressively put an end to an offending behavior. External reinforcement or support can come in the form of leadership or administrative counsel, reporting an incident through anonymous channels at an institutional or human-resource level, individual counseling or even professional support groups on social media outlets [14].

Several organizations and social media campaigns (e.g., Time's Up Healthcare on Twitter) are directed at calling out bias and microaggressions when they exist. Many of these organizations offer bystander intervention, conflict de-escalation and resilience training to encourage everyone to speak out when harassment is witnessed in the community or workplace. One such organization, iHollaback.org [15], emphasizes the Five Ds of taking action. These can be applied to forms of harassment or bias in the community

or workplace and can be modified as appropriate for the situation. The Five Ds are distract, direct, document, delegate and delay. "Distract" means to attempt to diffuse the situation by distracting the offender. By merely interrupting the offender with unrelated discussion, the encounter might be derailed. To be "direct" is to speak up, be firm and clear, let the offender know that you don't appreciate the comment, behavior, etc. "Document" includes writing down what happened with specifics, date and time. Some institutions have anonymous outlets through human resources for doing this. "Delegate" means to get help. Tell a mentor, residency program director, division chief, chair, ombudsperson, etc. Finally, "delay" — if you cannot act in the moment of conflict, you can still offer support. After you have witnessed the incident, comment, behavior, etc., check in with the victim and let them know that you are there to help and will serve as an ally. Share resources.

Reducing the impact of microaggressions

Specific strategies aimed at reducing the impact of microaggressions in medicine have been described. One example suggests targeting medical professionals early on in their medical school training to acknowledge and reduce microaggressions and their impact on patients [16]. White-Davis et al. [17] successfully implemented a workshop geared toward faculty at addressing racism in medical education. The workshop was developed by a diverse multidisciplinary team that identified essential elements in teaching about racism [17]. The 1.5-h faculty development workshop consisted of a didactic presentation, a 3-min video vignette depicting racial and gender microaggression within a hospital setting, small group discussion, large group debriefing and the presentation of a toolkit. The content of the workshop addressed physicians' roles as gatekeepers within systems, microaggressions experienced by clinicians and patients, and race as a biological versus social construct [17]. Open dialogue among the participants was encouraged within a safe and respectful environment, acknowledging that participants were present to learn from one another and that they themselves might need support in confronting personal bias that was uncomfortable to address. The authors then reviewed and analyzed participant surveys administered before and after the workshop. Participants improved their knowledge of the impact of racism on health inequities and of strategies to reduce racism at home institutions. Participants had more confidence in utilizing strategies to reduce racism in patient care. Last, participants were more committed to making personal changes to reduce health disparities [17].

Workshops are not the only way of tackling microaggressions in medicine. Increasing the recruitment and retention of diverse applicants inherently reduces microaggressions. In fact, diversity might be the best defense against the effects of microaggressions [18]. The experience of racial discrimination and microaggressions among monoracial people of color, multiracial people of color, and white people have been examined to determine whether individuals experience more or fewer microaggressions if they are in a racially homogeneous environment versus a racially diverse environment. In this subjective investigation, monoracial people of color and multiracial people experienced fewer microaggressions in a racially diverse environment [17]. Not surprisingly, white people experienced the lowest levels of microaggression in both homogeneous and diverse environments [18]. This evidence provides further support to efforts to diversify workforces to provide positive benefits to everyone who works within that organization.

Microaggressions have been likened to receiving a mosquito bite [19]. A single mosquito bite is a bit annoying but likely won't ruin a summer evening on the patio. However, if an individual is repeatedly attacked by a swarm of mosquitos, the experience can be more damaging. Furthermore, following such an experience, it is also understandable how additional mosquito bites might result in an individual being sensitized to even the smallest or mildest of bites, resulting in an outburst or reaction that might seem extreme. While the focus of this paper is on the impact of microaggressions on our interpersonal collegial relationships within our respective institutions, certainly there are many examples in the health inequities literature where microaggressions can impact our relationships with our patients as well.

We all took an oath to "do no harm" when we entered the profession of medicine, of course in relation to our patients. Perhaps it is time that we take that to heart during our interpersonal encounters with one another and think more carefully about the consequences of our comments and actions, whether intentional or not.

Declarations

Conflicts of interest None

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