Let Me Spell It Out: The Impact of Microaggression on the Health Care Professional

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CASE: **Rachel is a 10-year-old White girl with attention-deficit/hyperactivity disorder and a history of trauma who presented for evaluation by Dr. Narayanaswamy, a developmental-behavioral pediatrician. A pediatric resident observed the visit with permission from Rachel's parents.**

During the visit, Dr. Narayanaswamy spoke to Rachel's case manager over the phone to advocate for a trauma-based day treatment program at her school. At the end of the call, the case manager asked the physician for her full name. Dr. Narayanaswamy responded with her name and asked the case manager, "Would you like me to spell it?" At that time, Rachel's father began to laugh, shook his head, and incredulously remarked, "Ugh, yeah you need to spell it." Dr. Narayanaswamy ignored the comment and completed the phone call.

After the visit, Dr. Narayanaswamy explained to the resident that the father's derisive laughter was a microaggression. The resident appreciated the observation and, after a pause, asked why she chose not to defend herself when the microaggression occurred. Dr. Narayanaswamy reflected that she had refrained from responding to Rachel's father over concern that he would retaliate by providing low ratings on the postvisit patient satisfaction survey sent to all patients who received care at the institution. The granular survey results, comprising ratings in each survey subheading category for each clinician, are made public to members of her division each quarter, and low ratings are scrutinized by the leadership. Dr. Narayanaswamy thought it unfortunate that she felt inhibited in her response because this deprived the resident of observing ways to address microaggressions during an encounter, deprived herself the opportunity to respond directly to Rachel's father, and deprived Rachel from an instructive moment about racial empathy.

Dr. Narayanaswamy wrote a letter about the incident to the chief of clinical affairs to inquire what recourse clinicians had in these situations and whether certain patient encounters could be flagged to prevent the postvisit patient survey from being automatically sent. The chief responded that the incident was unfortunate and praised Dr. Narayanaswamy's restraint and professionalism but denied her request to have postvisit surveys blocked for certain encounters. He shared that if a clinician were to be dissatisfied with a visit satisfaction rating, the clinician could petition for a review, and a committee would subsequently determine whether the review could be removed.

How can health care professionals respond to microaggressions while maintaining a therapeutic alliance with the patient/family members and how can institutions support health care professionals in this endeavor?

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Microaggressions, defined as derogatory comments or behaviors toward another person based on an aspect of the recipient's identity, are often rooted in unconscious bias. While the intent of the comments or behaviors may not necessarily be to cause harm, they have a harmful impact and serve as a reminder that the recipient "does not belong" or is an "other."[1] Microaggressions do not present as an overtly discriminatory slur and may not be easily or readily identifiable, but the cumulative effects of repeated microaggressions in an individual's life—for which the moniker "death by a thousand cuts" was coined—include averse psychological effects, such as increased anxiety, depression, and trauma.[1] Without clear intention of harm, recipients may find it challenging to respond or may be wary of being perceived as overly sensitive.

The recipient of microaggression may respond in a variety of ways that can be helpful in fostering the recipient's ability to cope with the incident. Providing a

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direct response to the perpetrator can lead to a reduction in the recipient's racial stress.[2] In situations such as the one described for Dr. Narayanaswamy, patient-completed ratings of clinicians may curb a clinician's desire to respond to microaggressions for fear of lower ratings. Studies have shown that publicly reported ratings of clinicians are subject to bias in that (1) clinicians of color may receive lower ratings on consumer and patient satisfaction surveys[3–5] and (2) the rater may demonstrate a confirmation bias when evaluating a clinician (i.e., the rater is influenced by previously seeing a high or low rating for a particular clinician).[4] Therefore, the ratings themselves may not be a reliable measure of the care that was delivered. Quality measures should be implemented to ensure that patterns of harmful communication/behaviors demonstrated by a clinician do not continue, but it is equally important that institutions prioritize provision of support for clinicians who experience microaggressions because this contributes to the cultivation of an inclusive work environment for all clinicians. Institutions can take initial steps toward provision of clinician support by allowing clinicians to submit concerns that flag problematic encounters and by performing systematic evaluations to identify and mitigate bias that may exist within the clinician rating platform.[4]

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In a WebMD/Medscape survey of 822 physicians, 59% reported having heard an offensive remark about their personal characteristics over the past 5 years, with Black (70%), Asian (69%), and Hispanic (63%) physicians being more likely than their White colleagues (55%) to have heard biased comments. Thirty-one percent of the participating physicians reported being rejected by a patient because of their physical characteristics. Furthermore, women were more likely to experience bias based on their sex (41% women and 6% men), age (36% women and 23% men), and weight (15% women and 9% men), while men were more likely to experience bias based on their ethnicity (24% men and 20% women) and religion (15% men and 8% women).[1]

While balancing patient rights with physician rights may be difficult, physicians and other health care workers have employment rights that should be respected. According to Title VII of the 1964 Civil Rights Act, employees of health care institutions have the right to a workplace free from discrimination based on race, color, religion, sex, and national origin.[2] Many physicians, however, are in contract positions rather than directly employed by the hospital, making them ineligible for protection under Title VII.

Health care settings where microaggressions are permitted, through policies or lack of policies, create a sense of personal and professional invalidation among affected physicians, learners, and staff.[3] The Patient Rights Policy of Penn State Health Milton S. Hershey Medical Center prohibits patient displays of discriminatory behavior and communicates that such behavior will not be tolerated.[4] A similar policy and the opportunity to debrief with peers and the trainee would have provided Dr. Narayanaswamy an opportunity to process the emotional impact of the microaggression, validate her feelings, receive encouragement and support, and formulate possible responses to future incidences. Attendance and participation of the administrator and other members of leadership in the debriefing session would have allowed for discussion of the utility of a system to flag patient encounters during which discriminatory behavior occurred before the solicitation of patient feedback regarding the hospital, physicians, or staff, therefore reducing the impact of automatic and potentially unfairly punitive ratings of the clinicians.

Despite not feeling comfortable addressing the microaggression directly with the patient's father during the encounter, Dr. Narayanaswamy was able to distract from the microaggression by ignoring the father's statement and continuing with the visit. She involved an administrator with authority to make policy changes at the institutional level, formally documented the microaggression, and processed the emotional impact of her experience after the visit. Through the use of these strategies, Dr. Narayanaswamy modeled for her trainee how to be an upstander to microaggressions in health care.

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Since 1985, formal survey use in hospital settings has become commonplace. Today, patient feedback has significant implications, potentially affecting physicians' compensation, institutions' reimbursement,[1] and physicians' job satisfaction.[2]

There are several benefits to the review of patients' experience. First, improving the patient care experience is possible by reviewing existing perceptions of care. In addition, patient satisfaction has been shown to be associated with clinical care adherence and follow-up. Furthermore, patient satisfaction may also affect patient volume, a major driver of organizational revenue.[3] Hence, improving patient experience is beneficial to patients, health care professionals, and hospitals and medical practices.

However, as a standalone measure, the degree of patient satisfaction is not necessarily indicative of patient outcomes or future health care use.[4] In addition, survey results may negatively affect select health care professionals, with men and White clinicians more likely to receive higher scores.[5] Although the study of the role of bias in patients' satisfaction reports is limited, non-White American providers may be more likely to receive lower satisfaction ratings than White American counterparts.[3] Similarly, in a review of gynecologists' patient satisfaction scores, women physicians were less likely than men to receive top scores.

Patient satisfaction seems to be most strongly influenced by the relationship between the health care professional and the patient, as well as the clinician's communication skills.[6] Overall, patient experience measures are useful tools; however, bias may influence the results. Thus, it is advisable that patient satisfaction data be interpreted with caution and not be used as the only measure of patients' quality of care. Reliance on patient feedback, particularly for the compensation and professional development of health care professionals, is potentially detrimental, particularly for select clinicians.[7]

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Microaggressions are common in health care and are forms of interpersonal discrimination that occur routinely and usually go unnoticed by the perpetrator yet damage the target.[1] Microaggressions come in many forms that can be divided into 3 main categories:[1]

- Microinsults: statements that convey rudeness and insensitivity and demean a person's racial heritage or identity.
- Microassaults: explicit racial derogations characterized primarily by a violent verbal or nonverbal attack meant to hurt the intended victim.
- Microinvalidations: verbal comments or behaviors that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color.

In this case, the patient's father committed a microinsult against Dr. Narayanaswamy by making a demeaning comment about her last name, leaving her feeling insulted and angry yet powerless to defend herself because of institutional policies that fail to account for the impact of microaggressions toward clinicians. Although several models have been proposed to guide victims in response to microaggression, each puts the onus of managing the microaggression on the target/victim.[2,4]

- "Open The Front Door" (OTFD)
  - Observe: concrete, factual, and observable (not evaluative)
  - Think: thoughts based on observation
  - Feel: emotions—"I feel (emotion)"
  - Desire: specific request or inquiries about desired outcome
- A.C.T.I.O.N.
  - Ask clarifying questions to assist with understanding intentions
  - Carefully listen to their response
  - Tell others what you observed as problematic in a factual manner
  - Own your own thoughts and feelings around the impact
  - Next steps: request appropriate action be taken
- ERASE to support learners
  - Expect mistreatment
  - Recognize mistreatment episodes
  - Address the situation in real time
  - Support the learner after the event
  - Establish a positive culture

Health care professionals who repeatedly experience microaggressions are at higher risk for poor mental health, trauma responses, low job satisfaction, and burnout.[2,3]

Institutions have a responsibility to create a climate of respect, safety, and inclusion for all health care professionals and staff. Some action steps that institutions can take to create a climate such as this may include creation of a system that allows clinicians to report patient microaggressions, assurance that clinician reports will be taken seriously, ability to flag or remove patient satisfaction surveys that are linked to microaggression reports from the clinician rating, and enact measures to protect clinicians and staff from patient retaliation.

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Many clinical institutions track patient satisfaction scores and tie the scores to physician performance measures and/or compensation. Surveys of physicians have found that this has led to physician ordering of tests and/or prescription of medications that the physician believes are unnecessary or inappropriate, but are desired by the patient, to avoid negative scores.[1,2] These practices increase health care cost and expose patients to unnecessary risk and opportunity for adverse reactions.

Given the practice of tying patient satisfaction scores to physician performance measures/compensation, it is not surprising that physicians in this situation may not feel empowered to speak up or otherwise interrupt microaggressions or other discriminatory actions from their patients/patient families. As discussed by Dr. Spinks-Franklin, the intervention strategies often proposed place the responsibility to manage the aggressor's behavior and impact of that behavior on the victim. By training other professionals (e.g., medical trainees, nurses, and office staff) to use indirect and direct intervention strategies at times when discriminatory behavior is witnessed, those professionals can move from being simple bystanders to being effective and supportive upstanders.[3]

Unfortunately, there may be times that the behavior of the patient or patient's family is unremitting or egregious. In these settings, discharge from the practice may be the only reasonable choice. The American Academy of Pediatrics provides guidance for physicians as they move through this process, beginning with issuing a formal discharge warning, a template for a discharge letter explaining the reasoning for discharge and timeline for continued care, delivery of the letter by certified mail and inclusion within the medical record, and communication with other staff to ensure that all are aware of the decision and that the patient is not scheduled with the physician in the future.[4]

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