

Microaggressions: Privileged Observers' Duty to Act and What They Can Do

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Racism and sexism that manifest as microaggressions are commonly experienced by members of minoritized groups. These actions and comments erode their subjects' vitality and sense of belonging. Individuals from minoritized groups are often left in a quandary, weighing the potential benefits and risks of addressing the comments. Placing the burden to interrupt bias on our marginalized colleagues is unjust. In part, it is inappropriate to expect them to dismantle a system that they did not create. It is essential for individuals with privilege who observe microaggressions to address the speaker and support their colleagues. In this Ethics Rounds, we present 2 cases in which individuals from minoritized groups experience racism and sexism that manifest as microaggressions. The first case involves a Black female physician making recommendations in a business meeting being characterized by a male colleague as emotional. The commentators analyze how both gender and race constrain the range of acceptable emotions one may exhibit and the harm that this causes. The second case involves a Black intern being identified by a parent as a custodian. Commentators describe how such microaggressions can harm trainees' performance and sense of belonging. In both cases, observers did nothing or only spoke to the subject in private. Commentators provide specific guidance regarding actions that bystanders can take to become upstanders and how they can decenter themselves and their discomfort and leverage their privilege to interrupt microaggressions. By becoming upstanders, individuals can remove the disproportionate responsibility for addressing microaggressions from marginalized colleagues.

Microaggressions are everyday verbal, nonverbal, and environmental slights, snubs, invalidations, or insults that send hostile, derogatory, or negative messages to individuals solely on the basis of their marginalized group membership.¹ The term is a misnomer; "micro" refers to the subtle nature of microaggressions, which many people often dismiss as being small or insignificant in their impact; however, they are anything but subtle or insignificant to the individuals who repeatedly experience them.

Microaggressions take a toll on marginalized individuals, and their cumulative effect contributes to feelings of isolation, invisibility, and lack of value.¹

Racism and sexism that manifest as microaggressions in the workplace present dilemmas for individuals from minoritized groups on the receiving end of the microaggressive comment and for bystanders (the observers of these interactions). For individuals on the receiving end, the quandary

abstract

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involves weighing the emotional and professional costs of speaking up in environments where implicit and explicit biases are present versus the unspoken expectation and unjust responsibility to fight their own battles and dismantle systems of oppression, systems they did not create in the first place. Furthermore, the unyielding low threshold of disruption that will be tolerated from individuals from minoritized groups (particularly Black people) is very real. Among physicians traditionally underrepresented in medicine (UIM), disillusionment and fear of retaliation for speaking up against racism and other forms of discrimination are well documented in the literature.² These instances underscore the hierarchy and power dynamics at play that erode inclusivity and one's sense of belonging.

For bystanders, the dilemma in addressing microaggressions is usually rooted in the discomfort associated with speaking up as well as in what implications speaking up may have on their relationships, ability to fit in, and professional advancement. The actions needed to dismantle oppressive systems can no longer be ignored or postponed. Bystanders must consistently leverage their privilege to make substantive change in their workplaces and communities. When these individuals speak up, they take on the role of an upstander, the burden of disruption no longer rests on the shoulders of the marginalized; it is shared more broadly. We all have an obligation to stand up for our colleagues when they experience microaggressions of any kind. Only then will we truly reach our fullest potential as individuals and organizations.

In this Ethics Rounds, we present 2 cases in which individuals from minoritized groups experience racism and sexism that manifest as microaggressions in the workplace.

The cases are followed by commentaries from a pediatric surgeon, a pediatric hospitalist, a pediatric nephrologist, and an educator, who address the impact of interpersonal racism on individuals UIM and the importance of upstander interventions: situations in which bystanders or observers address biased or otherwise microaggressive statements or actions.

CASE 1

Dr Isabelle Smith is a Black physician in a large private pediatric practice. During a business meeting, Dr Smith and her colleagues were discussing modifying the clinic's hours. After several of her colleagues shared their thoughts, Dr Smith stated the reasons that she did not agree with the proposed solutions and suggested another potential solution. Dr Jason Doe, a White colleague interrupted, "Isabelle, we understand that you do not agree with us, but it would be best if you left your emotions out of the discussion." After the meeting ends, Dr Pam Jones, Dr Smith's friend with whom she completed residency, comes to her office, and apologizes for their colleague's comment and for not feeling comfortable speaking up during the meeting.

Dr Kotagal, a Pediatric Surgeon, Comments

In this case, Dr Smith's contributions to a discussion regarding changes to the clinic's hours are met with a response rooted firmly in her gender. This experience is one frequently met by women in the workplace, including those in medicine. The range of acceptable emotions for women is significantly restricted in professional (and often personal) settings. Emotions are often divided into those that are classically masculine, such as anger and pride, and feminine, such as

happiness and sadness. Expressions of anger in men are deemed to be congruent with the status and power thought to be associated with men, and thus men who express anger are more likely to be hired and given more status and opportunity. Women, however, experience the exact opposite. Women who express anger are less likely to be hired and are given lower salaries and less status.^{3,4} Women are expected to express warmth and nurturing behaviors but not anger or pride, which are considered dominant behaviors.

But even more central to this vignette is the labeling of women expressing any opinion as emotional. In addition to having a significantly restricted spectrum of societally acceptable emotions, the same emotions expressed by male counterparts are viewed differently. Men expressing emotion are viewed as passionate and dedicated, whereas women are seen as emotional or hysterical.³ Additionally, women are often believed to lack the ability to control their emotions. A similar reaction by a woman is more likely to be seen as overreacting rather than appropriate for a given circumstance.

This narrow spectrum of acceptable emotion and the view that women lack control of their emotions are subsequently used as tools to undermine professional legitimacy. Women are viewed as less competent when they express anger or as presumptuous for having dominant or masculine emotions.⁴ These assumptions and views on women result in penalties, for example, lower salaries, fewer promotions or opportunities, and less status, all of which continue to reinforce gender and power hierarchies in the workplace.

Women are acutely aware of this narrow spectrum of acceptable emotions. This awareness may lead women to self-analyze and overscrutinize their actions, trying to find the perfect balance on the tightrope. Women may do this to (1) avoid being labeled emotional and (2) avoid the potential negative career repercussions and lost opportunities that come with such a label. These actions may result in women stifling their authenticity and lead to imposter syndrome, a psychological term that refers to feelings of inadequacy that persist despite evident success. The concept, originally known as imposter phenomenon, was first described in 1978 and is characterized by chronic self-doubt and a sense of intellectual fraudulence.⁵ The phenomenon renders affected people incapable of internalizing their accomplishments no matter how successful and accomplished they are in their careers.^{6,7} Imposter syndrome is often characterized as an inherent flaw commonly seen in women rather than a byproduct of sexism and other forms of discrimination. Hence, those who experience imposter syndrome in professional settings can be worn down by instances in which their thoughts and ideas are minimized, whereas the inequitable systems and work environments that exacerbate imposter syndrome are left unaddressed.

In this case, Dr Smith has taken a measured approach to her dialogue with colleagues. She has allowed others to share their opinions while listening and then chooses to speak up, voicing both her perspective and another solution. Dr Doe does not address the potential merits or shortcomings of her comments and proposed solutions, instead he labels Dr Smith as emotional. Such labeling is harmful, gendered, and hinders

women and members of other minoritized groups from being their authentic selves and contributing their knowledge and experience in professional environments.

Dr Unaka, a Pediatric Hospitalist, Comments

In this case, Dr Smith experienced a microaggression, one to which many women can relate. Gender microaggressions convey a variety of messages regarding characteristics, roles, and abilities that are rooted in gender bias and discrimination. However, the message conveyed by Dr Doe was directly linked to his perception of Dr Smith as a Black woman. Intersectionality, a concept coined by Professor Kimberle Crenshaw in 1989, is a framework for understanding how different social identities (race, gender, class, disability, sexual orientation etc) overlap and create different levels of advantage and/or disadvantage.⁸ This concept is central to understanding that the discrimination Black women experience does not stem from a single system of oppression. The experiences of Black women are different from those of White women or Black men. Black women are subject to both racism and sexism; these compounding systems of oppression can have a tremendous impact on Black women and others with multiple social identities. For example, Black women physicians may experience being mistaken for a nurse in one instance and a member of a hospital's janitorial staff in another. Furthermore, Black women physicians receive less compensation and have less career advancement opportunities compared with their male and White female counterparts.⁹

Dr Smith's encounter with Dr Doe reveals the differential experiences

of UIM physicians in professional settings where othering and exclusion are commonplace. More specifically, Black women physicians are constantly combating negative stereotypes and pervasive tropes. A common trope is that of the "angry Black woman," one who is aggressive, easily provoked, hostile, irrational, loud, and ill-tempered. This mythical portrayal is harmful, and yet the pejorative stereotype can have a significant impact on the professional experiences and well-being of Black women. In fact, one study describes a phenomenon of racial fatigue, "the potential emotional and psychological sequelae of feeling isolated in a work environment in which race regularly influences behavior but is consistently ignored."¹⁰ Out of pure necessity, Black women are generally accustomed to navigating professional environments acutely aware of the preconceived notions and biases of their colleagues. Like Dr Smith, Black women are forced to make calculated decisions about if, when, and how to share their perspectives and/or address conflict. Black women recognize what is at stake and are weary of public exchanges in which the risk of being typecast or vilified is high.

The exchange between Dr Smith and Dr Jones is one that is all too familiar. Dr Smith's White colleague was silent during the exchange. The encounter highlights how those who experience racism and other forms of discrimination are often left to fend for themselves in various situations and environments. Dr Jones' inaction during the encounter warrants an examination of the role of allyship in cultivating inclusive environments. An ally is defined as an individual "who strive[s] to end oppression through supporting and advocating on behalf of the oppressed."¹¹ In this case, Dr Jones' allyship could be viewed as

complicated. Although she is not Black, as a woman, her ability to function effectively as an ally might be limited. That said, passive allyship, characterized by commiseration and offering emotional support to marginalized individuals behind the scenes, is woefully insufficient when it comes to mitigating microaggressions in the workplace.

Professional environments must foster inclusivity, an ideal state in which individuals are respected, empowered, and able to be their full and authentic selves. Inclusion is a dynamic process that can be promoted by enhancing institutional culture and climate as they relate to diversity, equity, and inclusion^{12,13}; practices that threaten its existence must be identified and eliminated. Inclusive environments are borne via dismantling social structures that confer disadvantage to marginalized individuals. And inclusive environments are sustained by those who are active coconspirators; individuals who recognize their privilege or unearned advantage and, as a result, leverage their position of power to center those who would otherwise be excluded.

Dr Hackworth, an Educator, Comments

It is common for bystanders to remain silent during and after a microaggression has taken place and approach the person who was on the receiving end of the microaggressive statement after the fact to either apologize for the offending colleague and/or apologize for not speaking up. Individuals can support of colleagues who experience microaggressions by being an upstander, a person who speaks or acts in support of an individual or cause, particularly someone who intervenes on behalf of a person

being attacked, bullied, or microaggressed.¹⁴ However, centering oneself and personal reasons for not intervening is unsupportive. Bystanders should keep in mind that addressing microaggressions does not have to be confrontational. Furthermore, intervention does not always have to occur in the moment. In fact, it is often more productive to request a one-on-one conversation shortly after the event.

There are many ways in which Dr Jones could have taken the posture of an upstander and educated her colleague, Dr Doe. To mitigate her discomfort with speaking up during the meeting, she could have either stayed behind and spoken to Dr Doe after the meeting or reached out to him via e-mail to set up a separate time in the near future to discuss what occurred. In either case, it is important for her to follow-up with her colleague, Dr Smith, to let her know that she found the comments to be offensive and to inform of her intention to speak with Dr Doe. Affirmation and support are critical to making Dr Smith feel that she is not overreacting. This approach also removes the burden from Dr Smith, who may be contemplating engaging in a conversation with Dr Doe.

If Dr Jones had a strong rapport with Dr Doe, she could say the following:

I wanted to touch base with you about the comment that you made to Dr Smith during this morning's meeting. John, I have known you for some time, and I know you would never deliberately say something to offend another person; however, it was very offensive to me when you interrupted Dr Smith as she was giving her perspective and told her "it would be best if you left your emotions out of the discussion." Assuming that a woman is being overly emotional when she expresses disagreement

is problematic and hurtful. This is deeply connected to biases and stereotypes that we hold about women, in this case, a Black woman. Have you ever heard of the "angry Black woman" phenomenon? I would be happy to get coffee with you sometime to share my experiences as a female physician as well as some things I have learned from our Black female colleagues. I also have a few resources that I will send you ahead of our meeting to make for richer discussion as we learn together and hold one another accountable for being better!

Many of the microaggressions that we witness result from a lack of awareness of the difference between intent and impact.¹⁵ When we intervene in situations such as the one presented above, we should engage with the mindset that this will be a continuous dialogue. The initial conversation serves as an icebreaker to let colleagues know that we are committed to their development and will approach difficult conversations with courage and compassion. Additionally, when we are on the receiving end of these conversations, we should accept feedback with grace and gratitude, understanding the significant amount of courage individuals must surmount to lean into these difficult conversations.

CASE 2

Dr Anaya Johnson, an intern, is rounding with her team, including attending physician Dr Robert Harvey. She identifies as Black and is the only person of color on the team. Dr Johnson enters her patient's room first and starts to introduce herself. The White parent abruptly interrupts her and says, "I am really glad you are here to empty the trash can! It's overflowing." Dr Johnson is caught off guard but pulls herself together and continues with her introduction and presentation. Dr Harvey looks mortified but does not intervene or

mention the incident to Dr Johnson afterward.

Dr Bignall, a Pediatric Nephrologist, Comments

Health care workers are human beings and are not immune to the impact of biased or bigoted statements directed toward them. This is especially true for many UIM students, trainees, and colleagues who are often working to counter racialized stereotypes about their presence on the health care team. It is in this context that Dr Johnson finds herself and in which her patient's parent exercised what could be described as a microaggression. Although perpetrators of racial microaggressions are often unaware that they are engaging in such communication patterns because they perceive themselves to be egalitarian, it is important to understand that when microaggressions target individuals on the basis of their race, the microaggressions are racist. Many times, this is the result of aversive racism, a form of racial prejudice held by individuals who outwardly endorse egalitarian beliefs and values but nonetheless hold prejudiced beliefs about members of certain racial groups.^{16,17}

There are some who might suggest that the parent in this vignette meant no harm by assuming that Dr Johnson, the only person of color on the patient care team, was part of the hospital's custodial staff and responsible for emptying the overflowing trash can. However, the response by Dr Johnson and her attending suggests a deeper understanding of the role of racist pretext in this assumption. It is unlikely that a nonminority resident team member would have faced the same assumption, and therefore this experience may lead Dr Johnson to conclude that she is not a properly respected member of the care team.

The internalized feelings that result from racist microaggressions can have

real-world consequences for Dr Johnson personally, for her clinical performance, and for her team's dynamics. Experiencing racism on the job is deeply demoralizing. The impact on one's psyche, sense of belonging, and mental health cannot be understated. But the impact does not lie with the target of racism alone. This racist microaggression can contribute to negative clinical performance because of Dr Johnson's hyperawareness of "stereotype threat," which acknowledges the increased anxiety that can result from excessive vigilance for how one's behavior may reinforce racist stereotypes.¹⁸ Finally, it is likely that if Dr Johnson and her attending recognized the racist nature of this microaggression, other members of the care team did as well.

Dr Hackworth, an Educator, Comments

Sadly, assumptions about Black employees' roles (including doctors, nurses, psychologists, other allied health professionals, and non-patient-facing staff) occur frequently in work environments. Most importantly, the microaggression is not an insult because of the position that the intern is being mistaken for holding because every colleague is a respected and valued member of the team. The issue lies in the underlying bias that is held about people of color, one that Sue et al¹⁹ coined "second class citizen," or the idea that people of color are servants to White people and could not possibly occupy high-status positions, such as physician, psychologist, nurse, respiratory therapist, educator, etc. Although this common microaggression is hurtful in many ways, the most harmful aspect of this case is that no one redirected the parent as the situation unfolded or followed-up with Dr Johnson afterward to provide her with the support she likely needed.

Clinicians who find themselves in positions in which they need to

address patients' or family members' microaggressive statements directed toward other members of the care team often find it difficult to do so for several reasons. Clinicians are balancing (1) concerns regarding the impact their actions might have on the establishment and/or maintenance of the therapeutic relationship, (2) their institution's espoused commitment to family-centered care, and (3) the negative impact speaking up may have on the clinician's patient satisfaction scores. The one factor that is not always considered in situations such as this one is the impact that unaddressed microaggressions have on colleagues on the receiving end. The literature is replete with findings about the detrimental impact that racism, such as that displayed in this case, has on the physical and mental health of those who experience it, including increased risk of chronic stress, mental health conditions, hypertension, and poor sleep-wake behaviors.²⁰⁻²⁴ Colleagues of color are not only experiencing racial bias that manifests as microaggressions, as outlined in these cases, similar experiences occur regularly outside the workplace as well. Although thresholds exist for the level of disruption that will be accepted by people of color before they are labeled as angry, negative, or not a good fit, situations such as those outlined in the case accentuate the unfair burden that people of color carry by having to either stand up for themselves or accept them as societal and workplace norms.

Although microaggressions alone are extremely erosive to one's self-esteem, self-efficacy, and overall well-being,²⁵ the compounding effect of colleagues not speaking up on behalf of the person experiencing the microaggression further exacerbates the many harms and detriments caused by these

experiences. Speaking up when one experiences or observes situations such as the one presented in this case presents several challenges that are important to consider. Speaking up may be prohibitive when a power differential exists or when there are real or perceived risks associated with addressing microaggressions. In this case, the intern may not have felt empowered to speak up not only because of her role as a trainee but also because of her racial and gender identity. The repercussions of interrupting bias are often amplified for people from minoritized groups simply because they are less likely to be afforded empathy or second chances in environments where racism, sexism, and bias exist, and yet although the risks and costs are greater, marginalized individuals are often left to address these issues alone because of the silence of bystanders. Thus, support for UIM trainees within graduate medical education programs is critical. Programs must create environments where trainees willingly escalate concerns to trusted mentors and/or graduate medical education leadership without hesitation or fear.

In this case, Dr Harvey could have engaged in a private conversation with Dr Johnson to provide her with support, affirm that the comment was in fact microaggressive and upsetting to him, and apprise her of his plan to address it. He then could address the parent with or without Dr Johnson present on the basis of her preference. An alternative approach would be for Dr Harvey to address the parent regarding the microaggression in the moment as soon as it occurred. If he chose to address the microaggression in the moment, it is critical to follow-up with Dr Johnson afterward to provide her with support. Dr Harvey could start the conversation with the parent by saying the following:

I am sure you did not mean to offend my resident physician, Dr Johnson; however, when you interrupted her and said, "I am really glad you are here to empty the trash can," that was very offensive. She has worked hard to become a doctor. Our hospital is deeply committed to diversity, equity, and inclusion and thus employs an extremely diverse workforce, so you can expect to see diversity across many different roles during your time with us. When you make assumptions that the Black person is here to empty the trash, you could be wrong and run the risk of offending the person. You could avoid that mistake in the future by checking out the person's badge or allowing the person to introduce her or himself and let you know their role.

If Dr Harvey had the time and felt equipped to go deeper, he could have shared with the parent how comments like that are rooted in biases and stereotypes that we hold about certain groups and that we all need to work hard to not make assumptions like the one made in this case. If the parent responds in a defensive or aggressive manner, Dr Harvey could say the following:

I know it can be hurtful to learn that you have offended someone, especially when you did not mean to. It can also make you feel embarrassed. Trust me, I have done the same thing many times before. I have learned that it is important to understand that just because I did not intend to hurt another person's feelings with my words does not mean the impact of my words is not hurtful. There is so much that I do not know as a White person, so I have really committed myself to embracing my missteps as learning opportunities instead of being embarrassed or defensive when someone brings them to my attention. This is a learning journey, and we are all in this together!

There are many scenarios, including the ones presented in this article,

that mirror the experiences of our colleagues from minoritized groups. We must create environments and spaces where people feel safe sharing their experiences and can practice responding to microaggressions. Practice is a powerful way for individuals to build confidence as it relates to bias intervention.

Dr Matheny Antommaria Comments

Although White, male physicians may be unaware of them, microaggressions experienced by minoritized groups are prevalent in health care. They have substantial negative effects on members of minoritized groups and on health care organizations. Racism and bias that manifest as microaggressions adversely affect the self-efficacy, vitality, and sense of belonging of members of minoritized groups. Organizations also lose their engagement and the benefits of their knowledge. Expecting members of minoritized groups to speak up in response to microaggressions is unjust. They did not create these systems of oppression, are already disadvantaged by them, and face additional risks of speaking up. These disadvantages and risks are exacerbated while individuals are in training. Bystanders with relative privilege must understand these dynamics and address them. Remaining silent makes one complicit in the racism and/or sexism. Individuals must move beyond supporting the targets of microaggressions in private as bystanders to responding to the perpetrator, at times in public, as upstanders. Although this must be done with tact, it is essential to decrease microaggressions, promote inclusion, and uphold institutional commitments to diversity. This requires courage and entails risk but is the right thing to do.

ABBREVIATION

UIM: underrepresented in medicine

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