Addressing the Elephant in the Room: Microaggressions in Medicine

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It was the beginning of the academic year. The intern was caring for a patient who needed a laceration repair. Earlier in the week, the intern had witnessed a nursing colleague prepare suture materials for a male resident without being asked. Today, the intern asked the same nurse whether she could help obtain suture materials for their patient, to which the nurse responded, "That's your job, not mine."

Unconscious and conscious sex-based bias toward female physicians is increasingly recognized in the medical community[1,2] and consistent with societal expectations of physicians and leaders being male.[3] From residency lore to mainstream press,[4,5] there are mentions of female physicians being called "sweetie" or "honey"; in response, many become well versed at reminding patients and colleagues of their qualifications as physicians. Although these encounters are traditionally associated with male patients or male professional counterparts, there is less discussion about these interactions occurring between female physicians and the predominantly female nursing workforce.

Effective communication between physicians and nurses is essential for high-quality patient care,[6-8] and yet communication can be challenging at times, irrespective of the hospital setting. The chaotic environment, fluctuating shift schedules, and steady stream of off-service rotators that characterize the emergency department (ED) in teaching institutions can make it especially difficult for residents and nurses to foster meaningful, longitudinal relationships.[9,10] Additionally, nurses have expressed feeling disrespected by physicians[6,11] even though nurses are often experienced health care workers who have nuanced and critically important knowledge of patients. Strategies proposed to improve nurse-physician collaboration include clear face-to-face communication,[7,12] respectful and active listening,[7,11,12] 2-way knowledge exchange with sharing of questions and concerns,[11,12] mutual task prioritization,[7] constructive conflict resolution policies,[8] and joint learning opportunities.[13] However, even with incorporating these strategies, female physicians face unique challenges when collaborating with nursing colleagues.[14,15]

Maintaining curiosity about medical decisionmaking is central to nurses' contributions to care, yet this curiosity can also be interpreted as biased communication toward female physicians. For example, when a nurse asks about a female resident's orders but accepts similar orders from a male resident without question, it is unclear whether this is due to the nurse's being more comfortable approaching a female resident to discuss management decisions or the nurse's not trusting the female resident's clinical acumen. Indeed, a study investigating the effects of physicians' sex on female nurses' behavior found that for the same clinical scenarios, "nurses were more willing to serve and defer to male physicians," yet tended to approach female physicians as equals and were both "more comfortable communicating with them…[and] more hostile toward them."[14]

The differential treatment of male and female residents by nurses is most obvious when male and female trainees work together. Male residents appear to garner more attention and responsiveness from nurses.[12,15,16] For example, qualitative studies have shown that female physicians often believe they receive less assistance than their male colleagues in regard to preparing equipment, finding case records, or organizing signed paperwork.[15] These examples, although likely of unintentional behavior, can cause female residents to believe they are undervalued and underqualified. Furthermore, although the tendency may be to ascribe these instances to intern naiveté, they have been observed at all levels of resident training.[15]

Consistent with these findings, a recent study demonstrated that despite equivalent competence as measured by in-service examination scores and milestone achievement, nurses evaluated female emergency medicine residents as having less ability and a weaker work ethic compared with their male counterparts.[17] A similar sex gap was revealed in a 2017 study examining faculty evaluation of

resident milestone attainment.[18] These studies suggest that implicit biases inform both nursing and faculty perceptions of female residents, which may in turn affect how female versus male residents are treated in the workplace.

Unconscious or implicit bias refers to attitudes or stereotypes about certain groups (eg, women, racial minorities, LGBTQ+ people) that affect understanding, actions, and decisions unconsciously.[19-21] These unconscious assessments or attitudes can be either favorable or unfavorable and are automatically activated. Unconscious bias may produce behaviors that are opposite to consciously stated values. The current medical workforce demographics create an environment in which existing differences set the stage for unconscious biases to affect behavior. According to the 2017 National Nursing Workforce Survey, registered nurses are majority female (90.9%) and white (80.8%), with an average age of 51 years.[22] In that same year, the Association of American Medical Colleges reported that 48% of enrollees in US medical schools were female and 52% were white, with an average age of entry into medical school of 24 years.[23,24] Demographically, medical school enrollees are younger and less homogenous than the nursing workforce. Additionally, a 2015 survey of US academic EDs showed that of 1,371 full-time faculty, 33% were female, 78% were white/non-Hispanic, 4% were black, and 4% were "other" (including white/Hispanic, Pacific Islander, multiracial, and Native American).[25] The survey highlighted the dearth of female and underrepresented minority faculty in emergency medicine, despite a more balanced representation in medical school. With the graduation of these medical school enrollees, the overall physician demographic will become more diverse, yet that of nursing and emergency medicine faculty remains relatively homogenous. As such, these groups differ in sex, race/ethnicity, age, etc, and thus it is more likely for unconscious assessments about "the other" to occur and affect professional relationships bidirectionally.

Although one may expect that sex-based treatment is difficult for female residents, female trainees from racial or ethnic groups that are underrepresented in medicine experience additional challenges.[26-28] When sex bias, conscious or unconscious, is overlaid on the racial and ethnic biases that exist in medicine, individuals at the intersection of these groups are cumulatively affected.[26-28] Intersectionality was first discussed by Crenshaw[29] in 1989 to describe the experiences of black women in regard to feminist theory and antiracist politics. Crenshaw[29] highlighted that the "intersectional experience is greater than the sum of racism and sexism, [and thus] any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated." Thus, the experiences of female physicians underrepresented in medicine may not fit into the framework used to understand the experiences of being solely a physician underrepresented in medicine, solely a female physician, or the sum of the 2 identities.

Sex and racial biases, in particular unconscious ones, often manifest in the form of microaggressions. Microaggressions were originally described by Pierce et al[30] in the context of theories of race and racism, as "subtle, stunning, often automatic, and non-verbal exchanges which are 'put downs' of blacks" and other minorities. "Micro" refers not to insignificance of these exchanges, but rather to their being "commonplace, daily exchanges."[31] Although the term "aggression" may seem harsh, it is important to understand its application within the context of intent and influence. Although a comment may not be intended to offend or cause harm, this does not change its effect on the receiving party. The importance of taking responsibility for the result of a statement, even when the intent is positive, is effectively

Table 1. Examples of microaggressions (adapted from Sue et al[36]).

Theme	Microaggression	Implication
Insensitive perceptions of physician identity	The resident speaks with her patient in Spanish and translates for the nurse, who does not speak Spanish. "You don't look like you speak Spanish!"	Native Spanish speakers appear a certain way.
Physician's heritage brought to bear in clinical care	The resident hands discharge paperwork for a Spanish-speaking patient to a nurse, with instructions written in English and Spanish. "Why don't you discharge the patient yourself? I don't speak Spanish."	Your time is not as valuable as mine.
Differential treatment of male and female physicians	During a code run by a female senior resident, the nurse asks what medications the male junior resident (even though he is not running the code) would like to order.	The physician who is in charge is most likely the male resident.

Table 2. Frameworks for responding to microaggressions.

Framework	Principles	Example
"Open the front door"	*O*bserve: concrete, factual, observable *T*hink: thoughts based on observation *F*eel: emotions *D*esire: request or inquire about desired outcome[40]	"I noticed that you interrupted me when I was talking to the patient [microaggression], which made me think that you didn't believe that what I had to say was important [implication]. I am frustrated [emotion] by this and hope that we can listen to each other more moving forward [desired outcome]."
ACTION	*A*sk clarifying questions. *C*ome from curiosity not judgment. *T*ell what you observed as problematic in a factual manner. *I*mpact exploration: Ask for or state the potential effect of such a statement or action on others. *O*wn your own thoughts and feelings around the effect. *N*ext steps: Request appropriate action be taken.[41]	"Earlier it seemed like you were surprised when I said that I am Latina [microaggression] and that I knew how to speak Spanish. Was that the case or am I misreading what happened [clarifying question]?" "Why were you surprised [curiosity]?" "I worry that when I make assumptions about others, which turn out to be incorrect, I make them feel less welcome [impact]. Has that happened to you?" "I think a lot about this because of the pain that my family has experienced in the past around the topic of 'who is Latino/Latina' [ownership]." "During our next shift, could we start with finding out who else is bilingual and is medically certified to speak with patients [next steps]?"
XYZ	I feel *X* when *Y* because of *Z*.[42]	"I feel uncomfortable when you ask me where I'm from because it makes me feel like I don't belong here."

illustrated through the lens of medical error. Imagine that a physician accidentally prescribes Levemir (a form of insulin) instead of the similar-sounding medication, Lovenox (an anticoagulant), and the patient subsequently becomes severely hypoglycemic. Although the physician's intent was to help the patient, harm resulted nonetheless, and the physician should understand his or her role in preventing future recurrences. Similarly, individuals who make comments that are experienced as microaggressions by the receiving parties may not intend for their words to be regarded as aggressive or discriminatory. Nonetheless, these words cause harm to individuals and groups who regularly experience differential treatment related to sex, race, ethnicity, or other social identities. Although microaggressions occur on individual and interpersonal levels, macroaggressions occur on institutional or systemic levels and manifest as biased or discriminatory policies, governance, and other practices that disproportionately benefit one group over another.[32] The interaction between the nurse and resident at the beginning of this perspective would thus be considered a microaggression and not a macroaggression. Although the female resident had a clear memory of her male counterpart being supported, it is most likely that the nurse did not recall providing such support, which makes bringing awareness about gendered behavior challenging.

The ways in which microaggressions manifest in medicine are a topic of increasing conversation.[26,33-35] Table 1 describes examples of microaggressions related to sex, race, or both that we or our colleagues have encountered in clinical practice. These examples build on the framework created by Sue et al,[36] which illustrates how microaggressions manifest. Most nursing-resident interactions are positive, respectful, and collaborative; however, the examples in Table 1 are shared to raise awareness of seemingly benign comments that can have a negative effect despite good intentions.

The effects of microaggressions extend beyond personal offense. Several studies examining how microaggressions affect women and those underrepresented in medicine, in particular, have linked microaggressions to the development of anxiety, depression, and even hypertension.[26,36] One study investigating racial microaggressions experienced by graduate students of color found them to be a significant predictor of burnout.[37] Another study examining the perspectives of nursing and medical students underrepresented in medicine highlighted that students thought that racial microaggressions

not only devalued their experiences but also negatively affected their learning, academic performance, and personal wellness.[38] Individuals receiving microaggressions often are unable to express the effect of these exchanges,[36] which can prove to be even more destructive to their mental health.

The first step in addressing implicit biases and microaggressions is to recognize that they exist. Although these experiences may be hard to digest and can elicit a sensation of discomfort or even defensiveness, the feelings of female physicians and physicians who are underrepresented in medicine should be acknowledged. Similarly, we must acknowledge, explore, and address the experiences of disrespect that have been shared by our nursing colleagues. Whether this is done through workshops, teaching conferences, or other educational modules, fostering open discussion is imperative. With this commentary, we hope to create awareness of ongoing workplace challenges and catalyze change in collaboration with our esteemed nursing colleagues.

The second step in addressing unconscious or conscious bias is to identify strategies to counteract it. One such strategy involves developing frameworks to respond to microaggressions directly in a productive and respectful way.[26] Table 2 illustrates 3 proposed frameworks for responding to microaggressions that can be used by recipients or observers of microaggressions.

Lastly, ongoing efforts are needed to diversify the physician and nursing workforce, strengthen multidisciplinary teamwork, and identify strategies to promote a healthy work environment. Specifically, further research is needed to elucidate adaptive responses that can be used to counter the deleterious mental and physiologic effects induced by microaggressions. One qualitative study focusing on strategies used by mental health professionals identified self-care, spirituality, mentorship, and collective organization as ways to establish resilience in the face of microaggressions in the workplace.[39]

Months later, as the intern reflected on her experience with the nurse and the suture materials, she realized that she had avoided any unnecessary interactions with the same nurse from that point onward. Furthermore, when she and the nurse were working during the same shift, the intern would grow tense and easily distracted.

Discussing disrespect or bias is both challenging and critically important; we hope this perspective stimulates awareness, reflection, and dialogue. By highlighting these issues, we aim to support colleagues who share these experiences and provide insight to colleagues who are unaware of them. We are deeply concerned about the tension created when nurses believe they are disrespected and when female physicians, particularly those underrepresented in medicine, experience implicit bias. This strain threatens communication, collaboration, and, most of all, patient care. Addressing these issues by creating physician-nursing partnerships focused on enhancing teamwork and shared decisionmaking is imperative to fostering an inclusive work environment and ensuring the best care for our patients.

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