A Little Hurts a Lot: Exploring the Impact of Microaggressions in Pediatric Medical Education

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"You have such a difficult name."

"You speak English so well!"

"Do you really eat bats?"

When Faiza, an adolescent patient, is told by her doctor that her name is difficult to pronounce, she hears, "You are different, and you don't belong." When a patient tells Christopher, a resident, that he speaks English really well, he wonders what assumptions they have made regarding his ability to be a good physician. When Kimberly, a medical student of Chinese heritage, is asked by her patient if she eats "strange foods" during the current coronavirus disease 2019 pandemic, she feels the sting of heightened xenophobia. Although possibly seeming benign, these incidents are the definition of microaggressions, like "death by a thousand cuts."

WHAT ARE MICROAGGRESSIONS?

Microaggressions, as suggested by the prefix, are not overt or grandiose displays of discrimination.[1] They are inherently nuanced discriminatory remarks or behaviors stemming from unconscious bias, often unintentional on the part of the aggressor. Although we focus on racist microaggressions in this article, many groups may experience them, including differently abled individuals, sexual and gender minorities, and religious minorities.[2] The subtle nature of microaggressions makes them difficult to identify and address for involved parties. Yet their damage is real and widespread, impacting medical trainees' learning, work performance, and even career decisions.[3] Thus, the learning environment may mirror harassment and discrimination that exist in society.

MICROAGGRESSIONS IN THE LEARNING ENVIRONMENT

The learning environment in pediatric medical education involves a number of participants: a learner (ie, a medical student or resident), an educator (ie, an attending physician, a resident, or an allied health care professional), and a caregiver, yet it is always patient centered. These relationships mean that the impact of the microaggression extends beyond the direct recipient: there is an impressionable child, youth, or student internalizing these exchanges as examples of the world around them. Microaggressions are not bounded by status and can be bidirectional; they can be inflicted by educators on learners, caregivers on learners, educators on caregivers, or educators on educators. The way these interactions are ignored or addressed sends a silent, but powerful, message to the child,

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As coauthors, we bring a diverse range of perspectives rooted in our identities and lived experiences. Ms Young (she and her) is a Chinese-Canadian senior medical student leader at the University of Toronto; Dr Punnett (she and her) is a white-Canadian pediatric oncologist and Director of Undergraduate Medical Education (Pediatrics) at the University of Toronto; Dr Suleman (she and her) is an Indo-Canadian Muslim pediatrician and Assistant Professor at the University of Toronto (Pediatrics); and all authors contributed equally to the conceptualization, drafting, and revision of the manuscript, approved the final manuscript as submitted, and agree to be accountable for all aspects of the work.

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youth, or student about what is acceptable and whether they are accepted in the world. The impact of discrimination on child health is significant, from worsening mental health to high-risk behaviors[4,5] and it is paramount that as pediatric educators, our learning environment does not contribute to this.

Unfortunately, microaggressions in medical education remain a daily reality for many trainees. At vulnerable stages in their careers, these negative encounters may leave trainees with a sense of "otherness," reinforcing a feeling that they do not fit the archetype of a certain specialty, setting, or medicine broadly. Moreover, trainees are tasked with building resiliency and maintaining wellness in a milieu that not only fails to evolve with them but provides repeated insults to their self-worth. Similarly, although society places physicians in positions of privilege, physicians from marginalized groups regularly experience microaggressions, themselves. Microaggressions may erode a sense of self-efficacy,[6] blunting the trajectory of rising clinician leaders and educators, further perpetuating the homogeneity among medical faculty. For both learners and health care professionals alike, the damage inflicted by microaggressions is pervasive and potent, associated with increased depression, anxiety, and trauma.[6–8] We must make a commitment to support one another; a more-unified and tolerant medical community not only promotes wellness among health care professionals but may also improve health outcomes for patients.[9]

Microaggressions have become so ubiquitous that it can be difficult for those affected to speak out about each isolated event without seeming overly sensitive. Although resilience helps trainees navigate some of the challenges they will face in medicine, we cannot call on students to mitigate these encounters with coping strategies alone. Clinical educators can serve as powerful allies to support and empower trainees who are experiencing mistreatment. Yet, although many teachers feel compelled to answer this call to action, they may also feel ill-equipped to translate those feelings into practice. It is critical to train all educators and learners to prepare for, recognize, and respond to microaggressions to mitigate their effect and provide a supportive learning and practice environment for our teams and patients (Fig 1).

OPPORTUNITIES FOR EDUCATORS

First, we recommend that all learners and educators receive formal education about explicit and structural racism and discrimination and be encouraged to engage in candid personal and group reflections on their historical underpinnings and modern manifestations. Many institutions now recommend training to identify one's own implicit associations or bias.[10] Group reflections allow for the sharing of lived experiences of microaggressions and can help staff and learners practice potential responses.

Second, we urge clinical educators to take responsibility within the clinical context to identify and address microaggressions in the moment, naming the behavior as inappropriate and refocusing the interaction to the professional context for the actor and any involved trainees. These in-the-moment interventions can be done respectfully by directly reframing a response. In Kimberly's case above, if witnessed by the educator, they can refocus the interaction on the patient's immediate needs; this pivot may also draw the patient's attention to the inappropriate nature of their remark. After this, the educator should debrief the interaction with the trainee in a neutral, safe space to provide support and acknowledge the impact of the microaggression.

EDUCATOR-LEARNER OPPORTUNITIES

Beyond addressing witnessed interactions, we believe educators should create spaces for trainees and educators alike to disclose experiences of microaggressions, whether this occurred as the recipient or the actor. Critical reflection around the impact of the interaction encourages analyses of behaviors,[11] helping to shift the onus away from expecting trainees to suppress reactions when facing discrimination and, instead, placing responsibility

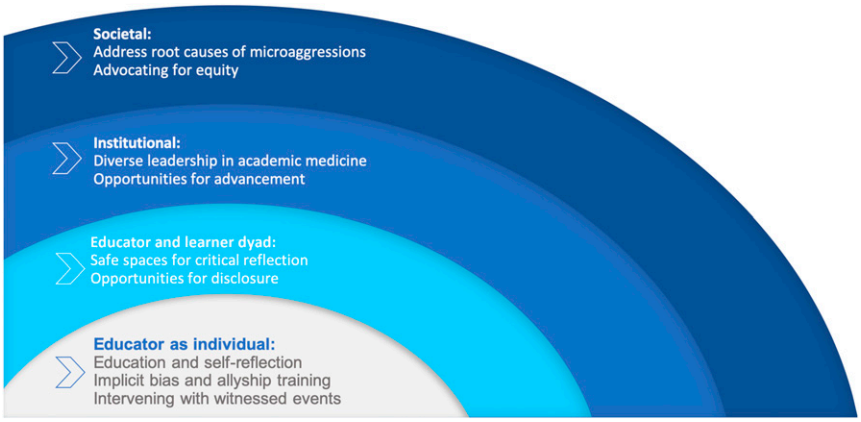

FIGURE 1
An approach to addressing microaggressions in medical education. Strategies at the individual, educator-learner dyad, institutional, and societal levels may support the mitigation of microaggressions in medical education.

on educators to increase their sensitivity and awareness. After all, each of us can control what we ourselves say, but others cannot control what they hear or how it makes them feel.

OPPORTUNITIES FOR INSTITUTIONS AND SOCIETY

Third, we strongly recommend increasing diversity within medical education leadership, such that more individuals in positions of power share the experiences of their trainees. It is important to build relationships to create solidarity with marginalized groups, in other words, to become an ally. However, it is impossible to respond to a transgression when you are unable to recognize it. Because microaggressions are subtle, the progress we stand to make through our allies is often limited by their lack of lived experiences. Currently, the demographics of academic pediatric leadership does not reflect their learners or the general population.[12,13] One way to increase diversity is by explicitly valuing different strengths and experiences in academic medicine, particularly in candidates being considered for recruitment and advancement. Increasing pressure on medical faculty to excel solely in research effectively minimizes the importance of excellence in teaching, clinical service, and advocacy.[14] With an ever-evolving scope of practice, we believe that our institutions must consider the broad definition of academic scholarship to give merit to less-tangible, although equally significant, means of productivity; for example, community leadership and engagement.[15] Finally, both educators and learners can strive to address the root causes of microaggressions and advocate for a more-equitable society.

CONCLUSIONS

In an increasingly pluralistic world, we can look to a future when microaggressions are acknowledged, addressed, and ultimately no longer exist. In our previous examples, Faiza would be asked how best to pronounce her name, Christopher would be praised for his bedside clinical skills, and Kimberly would feel empowered after her preceptor's intervention. It is this world that we want our patients to see and our learners to grow in and one that we can achieve with a concerted effort to acknowledge, identify, and address.

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