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| Let learners know that you (the facilitator) will read the case aloud. Ask the learners to pay attention to identifying any microaggressions they notice. No matter what framework they use to respond, IDENTIFYING the microaggression is an important step. If a learner identifies a microaggression, they should pound on the table (like a Taboo buzzer). If it is something that others may not recognize as a microaggression, you may ask the person who identified it to describe WHY it is a microaggression; or you can describe this yourself. Some are obvious and do not require further explanation. The learner should then use one of the phrases from their ‘minimalist’ toolkit, or a more detailed/elegant phrase if they feel so inclined, to interrupt the microaggression. Reassure learners that they do not have to have a perfect response—we want them to get used to responding even if they don’t feel like their language is exactly right. Sometimes better is the enemy of good. No response at all communicates that the microaggression is OK.  Ground rules for this particular exercise:   * As a default, all residents should respond as if they are observing the incident as a witness.   + If the resident wishes to act as the individual experiencing the microaggression, AND they hold the identity consistent with the microaggression described, they may ask to do so.   + Learners should never take on a marginalized, oppressed or underrepresented identity they do not hold * Those experiencing a microaggression may respond or choose not to, and should be supported however they choose to respond * Those who witness or hear about a microaggression SHOULD respond. Do not assume someone else will respond. * This is intentionally redundant. Most people need to practice hearing and saying these words a few times in a low stakes situation (such as this session) before they are able to apply them in a real world setting.   *Note to facilitator: examples of microaggressions are underlined in this written version of the case for your reference, but you should not identify these for the learners unless they are having difficulty.*  **Case 1:** A 17-year-old male, Sam, is admitted in the very early hours of the morning with a change in mental status. Isabel Intern, who is an Asian-American female, picks up Sam. On morning rounds, she presents that his change in mental status was due to polysubstance ingestion and intoxication. Upon entering the room, the team finds a somnolent Sam dozing off while having his breakfast. He becomes more alert and looks around the room at the team: a male attending, a male senior resident, Isabel Intern, another intern (who is male), and a female medical student, Sally Student.    The attending asks Sam how he is doing, but his response is difficult to apprehend. When asked to repeat himself, he points to Sally Student, who is Black, and states, loudly “I do not want her here!”  The attending then asks Sally to check on the next patient, and she leaves the room.    Changing the subject, the resident asks the patient if the team can examine him. “Of course! Where’s that hot nursing student?” he states with a smile, motioning to Isabel Intern. While assessing Sam’s pupillary reaction, the attending asks him to focus on a spot across the room. He makes eye contact with Isabel Intern and asserts slyly, “You’re too hot to be working here! Where are you from anyway?”    The team concludes the visit and leaves the room, where they reconnect with Sally Student. She has just visited another patient. While discussing the medical plan for Sam, the attending states to the team he feels they “handled the interaction professionally.”  This section adapted from: Sandoval RS, Afolabi T, Said J, Dunleavy S, Chatterjee A, Ölveczky D. Building a Tool Kit for Medical and Dental Students: Addressing Microaggressions and Discrimination on the Wards. MedEdPORTAL. 2020 Apr 3;16 |
| 1. **Ask residents to identify the microaggressions they noticed in the case** 2. **Guide discussion based on the issues raised by learners: Plan to cover at least three of these points. *You need not cover all of these points.*  Spend no more than 20 minutes on this aspect of the discussion (watch the clock!).** **“I do not want her here!”**    1. This is more akin to blatant discrimination or a microassault. Of course, the patient does not explicitly state that he does not want the student in the room *because* of her race. Students may question how we know that this was an incident of discrimination. This incident is based on something that happened to an student, who questioned whether she was asked to leave not because of her race, but rather because the patient simply did not want a student in the room. In this case, the patient does not ask the other female student, who is Asian, to leave the room, increasing our suspicion that his request was discriminatory and based on race. We would like to stress that it is also not intent of the request, but how the intent is *perceived* by the recipient.    2. This incident provides an opportunity to discuss the different perceptions between the Asian-American and Black students. The main difference between these two students that we would like to explore is their race, as the patient was unlikely to know that the Black student was more junior to the Asian student. The juxtaposition of the patient’s reaction to the two students provides an opportunity to discuss the role of Asian Americans as the “model minority” and how this ideology is used to discredit and alienate Black and Latinx Americans. How can students who benefit from this perception serve as allies to those subjected to more negative stereotypes?   **The attending then asks Sally Student to check on the next patient, and she leaves the room.**   * 1. This action should be addressed as a separate issue from the microaggression itself. The attending, as the leader of the team, is the most authorized person to respond to the patient’s request. The attending may have thought that refusing the patient’s request in the moment would have further escalated the situation and put Sally Student in greater harm. By honoring the request without explaining to the team why, the attending simply validates the patient’s racism and sends the message to the team that this bigoted behavior is acceptable. The attending leaves the students to question not only why the patient made these comments, but also to hold the attending responsible for complying with the request in the first place.   2. In terms of responding to the patient’s request, the attending has a few options. One option could be to ask Sally Student to leave the room and facilitating a restorative conversation with the team afterward, as described above. An even better response would be to employ a framework such as the one created by Kimani Paul-Emile et al. in “Dealing with Racist Patients.” According to this model, the attending would ask the patient to explain why he was requesting that Sally Student leave the room. The patient may realize that his request cannot be adequately justified and concede. Or, the patient may proceed to justify his racist request, in which case the attending would need to respond. The attending could state that there is simply no tolerance of racism, sexism, or any other form of bigotry in the hospital. Regardless of how the attending chooses to respond in the room, it is still the attending’s responsibility to facilitate a conversation with each member of the team following the incident and to ensure that Sally Student and Isabel Intern are connected to supportive resources afterward.   3. We intentionally do not focus on analyzing the attending’s response to the patient in this workshop because it is designed for residents. However, it is important to note that the attending’s response to this patient is inappropriate and ultimately puts an undue burden on the students to navigate this difficult situation on their own.   **“Where’s that hot nurse?”**   * 1. The patient mistakes Isabel Intern for a nurse. Many women physicians have stories of being mistaken for nurses based on their gender, and in some cases, based on race and ethnicity as well. Though not directly addressed in this case, physicians and physicians-in-training who are not of the same background as traditional physicians (namely white and male) may be mistaken for other (usually “lower” on the hierarchical rank) members of the healthcare team.   2. We should also interrogate why it is that we consider being confused for a nurse as problematic. On one hand, gender stereotypes are harmful and frustrating to navigate, especially when we feel that women’s rights have progressed extensively over the last few decades. On the other hand, this frustration may stem from internalized superiority and elitism. Women physicians and physicians-in-training may see themselves as being “better” than nurses and do not want to be confused for one. In fact, some female physicians wear white coats primarily to avoid this confusion.   3. This statement should be considered in terms of race, as well as gender. The student physician in this case is Asian-American. Asians make up 3% of the U.S. population and about 12% of the physician population. We can imagine a situation in which members of racial groups that are underrepresented in medicine may have an even greater burden of having to justify their role on the healthcare team. For example, 12% of the American population is Black, yet only 4% of all physicians are Black.   4. It can also be expanded to consider other members of the healthcare team, including patient care assistants and house staff, who are often people of color. These racial and gendered stereotypes may lead to distrust between the clinician and patients and the clinician and other members of the healthcare team. Jennifer Okwerekwu, at the time a psychiatry resident who is Black, writes “All this time I spend explaining who I am is time I’m not spending being who I am” when describing the emotional exhaustion of having to continuously explain that she is a doctor.   5. Assumptions of the roles in the healthcare setting based on anything other than fact can directly harm patient care. This racist and gendered skepticism can affect the ability of a healthcare provider to do their job. Dr. Tamika Cross made national news when a Delta flight attendant prevented her from assisting a patient during an emergency, prompting other physicians of color to share similar stories via the #WhatDoctorsLookLike campaign on social media. Similar phenomenons occur within the healthcare setting. Some physicians of color, especially women, describe being questioned more by nurses than their male counterparts, confirming feelings of self-doubt and inadequacy that contribute to burnout and compromise patient care.   **“You’re too hot to be working here.”**   * 1. This comment has a sexual undertone and could be characterized as both a microaggression and blatant harassment on the basis of gender and race. Again, this is an example of a comment that was likely not made with the intent to harm; the patient likely thought he was being complementary and humorous. This sexist comment is directly harmful to women in the healthcare setting, who seek to be treated as equals to their male counterparts. Worse, women are blamed for attracting the male gaze, resulting in the policing of the female appearance with formal policies such as dress code and more informal codes of conduct.   2. Harassment on the basis of gender especially has no place in the healthcare setting. It is worthwhile to note that this comment was adapted from a real comment a preceptor made to a female student. The male preceptor asked a patient to focus on the “pretty medical student” and then corrected himself stating, “Oh I’m sorry, nowadays we’re supposed to say ‘strong, independent female.’” In another case, a female student was subjected to harassment from a patient during a geriatrics visit in May. Her preceptor was observing the interview and neither intervened nor approached the student following the interview. Of note, some students have expressed that these incidences are bound to occur, and that it’s “just what comes with being a woman.” Our goal is to challenge this idea and to equip students with the tools to create a learning environment in which these incidences are rare and taken seriously.   3. In this case, the patient is the one making this comment. Nonetheless, the implications of the male gaze from of other members of the healthcare team are worth noting. Specifically, what should students do if harrassed by another member of the team, especially if that member is of a higher rank?  Stories of female students being sexually harassed by male residents and attendings at HMS and beyond are not uncommon. These incidences are more likely to occur later in medical training when students have more clinical experience. Some of the targets of harassment express fear of retaliation when explaining why they did not report this incident. The national conversation surrounding the #metoo movement has begun to infiltrate the healthcare field. Alleged sexual abuse from Dr. Larry Nassar (Michigan State University and USA gymnastics team doctor), Dr. George Tyndall (USC student health center doctor), and Dr. Richard Strauss (Ohio State University wrestling team doctor) has made national news over the last year. In all of these cases, patients have come forward to describe incidences in which physicians have abused their power.   4. This statement should be discussed in the context of the student’s Asian-American race. Coupled with the next statement (“Where are you from anyway?”), this is a clear case of exoticization. Asian women in particular are subject to fetishization, stemming from stereotypes of sexual subservience. (While Black women may also be fetishized, the patient’s reaction to the Black student fits more in line with the notion that Black women are undesirable).   **“Where are you from anyway?”**   * 1. This microaggression is considered a micro*invalidation* because it demonstrates the assumption that non-white Americans are foreigners. Asian-Americans are often the targets of this “alien in your own land” perception. Other comments that illustrate this perception include “You speak good English” and “Where were you born?” These comments can be interpreted as benign small talk or even complementary; in fact, they are rarely meant to be malicious statements. Recall that the definition of microaggression that we present in the didactic session includes both intentional and unintentional slights. These statements can make the recipient feel that they do not belong and can contribute to the larger political xenophobic climate. It is interesting that the patient asked the student who is Asian American where she is from but did not ask the same question to the other members of the team.   2. The impact of this statement on patient care can take many forms. In some ways, it can be extremely exhausting to have to justify that you belong. It may feel begin to feel like the student is a foreigner not only in the country, but also in the healthcare setting or as a member of the care team. Students who have been asked this question many times may have already developed coping mechanisms, including ignoring these statements, responding with sly remarks, etc.   **“Handled the interaction professionally”**   * 1. The preceptor missed a crucial opportunity to address what had just occurred in a meaningful way that could have minimized the harm endured by his team. He not only missed this opportunity, but he also caused additional harm by imposing his expectations of professionalism on his team. “Professionalism” is often rooted in a white supremacist ideology of what behavior looks like, and what behavior is acceptable in professional spaces. These whitewashed codes of conduct leave little room for inclusion of people from different backgrounds and cultures. For instance, a gay student in our class has been told by preceptors that he is “unprofessional” due to his more feminine-presenting demeanor.   2. It is telling that “professionalism” requires that Black and Latinx people to remain complacent in the face of blatant discrimination. Sally Student was expected to leave the room amicably. It is crucial to recognize that professional behavior is of greater burden to people of color, especially in these situations.   3. Not all faculty may be equipped with the tools to support learners through an experience like this. Whose role is it to help faculty develop this skill set? Hospital leadership? Learners?  1. **If time permits,** consider discussing the following additional questions:    1. **How does the patient’s mental status impact your understanding of this case? Do altered mental states cause patients to express problematic views? Are these the views they truly hold deep down or are they completely foreign? Is this distinction important?**   The patient’s mental status in this case is pertinent, and should be discussed explicitly if not brought up by students. Some students might use the patient’s mental status to justify his comments. Students may think and express that the patient was not in complete control of his own thoughts and actions due to his mental status. The case mentions that the patient is likely intoxicated and was admitted for a change in mental status. It is possible that the patient’s behavior was exacerbated by, but not caused by, his change in mental status. We can debate whether these statements and behavior would or would not have occurred if the patient was in his normal state of mind. However, regardless of whether his mental status should be used as justification, the patient’s comments require a response because these comments cause harm regardless of intent (this is a point that should be stressed for all microaggressions).   * 1. **How do you think age of the patient played a role in the case? How does age in general play a role in what we tolerate?**   This is an adolescent patient. There is often an assumption that the elderly and adolescents should not be held to the same standards of conduct.  This section adapted from: Sandoval RS, Afolabi T, Said J, Dunleavy S, Chatterjee A, Ölveczky D. Building a Tool Kit for Medical and Dental Students: Addressing Microaggressions and Discrimination on the Wards. 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| For reference, here is the language from the toolkit:   1. UW Health does not tolerate bigotry. Being a patient at UW Health means treating people respectfully. Let’s refocus on how I can help you today. 2. Our role is to take the very best care of you. We are here to help you as a team. We do not change (doctors, nurses, etc.) because of their (race, ethnicity, religion, etc.) 3. UW Health is committed to being a diverse and inclusive environment for all. |