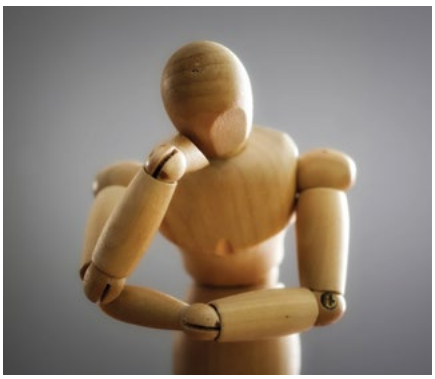
Microaggressions in the general practice setting



CPD

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Background
Microaggressions are pervasive problems in the workplace; the general practice setting is no exception.

Objective
This article examines what microaggressions are and outlines the key roles of protagonist, target, bystander and ally. It explores the effects of microaggressions on target persons (how microaggressions can affect their physical or mental health), and the implications microaggressions might also have for patient safety and broader workforce security.

Discussion
The article concludes by considering professional development strategies that can be adopted, including how to move from a position of bystander to ally.

A GROUP OF COLLEAGUES stand about the tearoom in a rural practice chatting about their footy tipping results over coffee. Imelda, a former international medical graduate and person of strict faith, enters the room, looking forward to some respite after a long morning session. Imelda believes footy tipping to be a form of gambling. Although she does not want to personally partake in it, she would still like to be accepted in her new practice. The footy tipping organiser considers Imelda's beliefs to be weird. As Imelda says hello, the group look at each other, and the conversation ceases. Imelda interprets this as being excluded by her colleagues. She pours herself a coffee and leaves the quietened tearoom, after which the group conversation continues.

John is an enthusiastic new Fellow. Meredith is a registrar who has a speech impediment. John finds this frustrating to listen to and will often speak over Meredith in meetings. He uses a mocking tone to show Meredith his disdain whenever she tries to speak. This makes her very uncomfortable, even though she has come to expect it. When she does try to speak, her words become increasingly faltering. Some conclude that she is not confident and, by extension, not competent. Rachel is a new registrar who notices John's behaviour towards Meredith and finds it aggressive but does not want to speak up in case she loses her job. She tried to speak up in a previous practice when she witnessed covert bullying, but the personal consequences were high. She feels conflicted.

Zelda is the practice manager who is having difficulties managing her recent recruit, Kristy, whom she line manages. Kristy has high energy and has quickly befriended most of the other office staff on social media and is very self-promoting. Behind closed doors, Kristy has become increasingly recalcitrant and rude to Zelda. Zelda seeks advice from the practice owner, Ahmed, only to learn that Kristy has already been to him to complain about her line manager. Zelda is shocked. As Kristy's 'concerns' about Zelda's abilities as practice manager become more public, Ahmed calls a meeting. Zelda is hesitant because she is feeling increasingly concerned and unsupported. In the meeting, Kristy enters the room last and sits with her torso angled away from Zelda, signalling her displeasure at Zelda's answers through huffs, sniffs or the rolling of her eyes. In her responses to Ahmed, Kristy refers to Zelda's advancing years and that she could take on some of her role to help. The practice owner agrees that Zelda is getting closer to retirement age, and it would be good to have a succession plan in place. Before the end of the meeting, some of Zelda's responsibilities

are apportioned to Kristy. Ahmed misses seeing Kristy turn and give Zelda a triumphant smile as she leaves the room.

What are microaggressions?

The commonality of these examples, an amalgam of multiple real-life anecdotal experiences, is that they are all forms of 'microaggressions'. The literature defines microaggressions as 'verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons'.[1] The coinage of the term is attributed to Chester Pierce in the 1970s, who used it to refer specifically to the indignities experienced by African Americans.[2] Over time, the term has been expanded from racism, to other '-isms',[3] encompassing all situations in which words, actions and behaviours cause intended or unintended harm to individuals and groups.[4] This includes other forms of oppressions,[5] such as ageism, sexism, ableism, classism, heterosexism and faithism, which undermine workplace effectiveness and stability.[6]

Microaggressions can be difficult to pinpoint. They can be 'subtle snubs or dismissive looks, gestures, and tones',[7] or 'small comments that could pass off as innocent, but they can make victims feel like they are being mistreated or excluded'.[8] If not obvious, they might go unnoticed or be overlooked by others. Yet, for the target, they can be perceived as being discriminatory, prejudicial, abusive, malicious or harassing. When coupled with implicit bias (defined as unconscious prejudice in favour or against the target), the effects can be psychologically damaging.[9]

Four key roles

There are several key roles that are enacted in microaggressions. These are the protagonist, the target, bystanders and allies.

The protagonist, also referred to as the 'microaggressing agent',[10] is the perpetrator of the microagression, whether deliberately or unconsciously. Their words and actions disempower targets by dismissing, degrading, demoralising or shaming, causing stress, instilling fear, or harming a target's credibility.[11]

The target is the recipient, the individual (or group) who feels victimised by the protagonist. To help overcome any trivialisation of the effects of microaggressions, Freeman and Stewart[12] suggest understanding microaggressions through a 'harm-based' lens that places the focus on the target and the harms they experience.

Bystanders are the third role. This group has a powerful opportunity to intervene because bystanders are neither protagonist nor target.[13] However, there are five reasons why bystanders fail to act or speak up. These are: the invisibility of the bias; trivialisation of the event; diffusing of responsibility; fear of retaliation or repercussions against themselves; and/or not knowing what to do (paralysis).[14] As Sue et al note:

> *For too long, acceptance, silence, passivity, and inaction have been the predominant, albeit ineffective, strategies for coping with microaggressions. Inaction does nothing but support and proliferate biased perpetrator behaviours which occur at individual, institutional and societal levels.*[14]

Sadly, it can be a very cold and alienating workplace for the target when there are no allies (the fourth role). Allies are individuals who, through their support of targeted individuals or groups, actively work towards overcoming any prejudicial practices that they witness.[14] The positive effect of the presence of allies to a target cannot be understated.[13]

Types of microaggressions

There are four subtypes of microaggressions that can occur in the workplace:[13] microassaults, microinsults, microinvalidations and environmental microaggressions.

A microassault is defined as an explicit derogatory verbal or non-verbal attack meant to hurt the intended victim through name calling, avoidant behaviour or purposeful discriminatory actions:[7]

> *I wanted the White doctor to see me.* (A patient referring to a registrar over the experienced general practitioner [GP] supervisor)

Microinsults are defined as subtle snubs or humiliations that convey demeaning messages to the recipient:[13]

> *Oh, I thought you were the receptionist.* (A new practice GP referring to the practice's only female GP)

Microinvalidations can be trickier to discern than microassaults and microinsults, especially for bystanders and allies. A microinvalidation aims to purposefully exclude the target, or to negate or dismiss the targeted person's personal thoughts, feelings or experienced reality:[13]

> *You always overreact!* (A condescending comment from one colleague to another to invalidate their alternative opinion on a matter)

The final category is that of the context in which microaggressions take place, and points to culture. Environmental microaggressions are defined as something in a person's environment that sends a message of invalidation towards a marginalised person,[15] cultural group, history or heritage.[16]

Microaggressions: The elephant in the room

Microaggressions can take place on personal and interpersonal levels, in public and private situations or, simultaneously, both.[14] They reflect beliefs about inclusion or exclusion, superiority or inferiority, normality or abnormality and desirability or undesirability. These views can relate to race, age, gender, geography (eg rural vs metropolitan), finances or simply not being in the 'in' crowd. All relate to attempts to deride, to show superiority and have coercive control.

According to Molina et al,[4] exploring microaggressions in the field of medicine is addressing 'the elephant in the room'. When these practices become more

broadly institutionally entrenched or reach systemic levels, they are termed macroaggressions, resulting in biased or discriminatory leadership and practices that can advantage some over others.[14]

Why microaggressions are worth calling out

Microaggressions are more than a simple annoyance like 'swatting mosquitoes'.[17] They eventually affect everyone in the general practice setting.

Pierce, in his seminal work, argued that the effect of microaggressions serves to psychologically keep the target accepting of their disenfranchised state.[2] This can usher in a low quality of life, with psychological and physical impacts.[13] Targets can also internalise the vilification. In the extreme, microaggressions can ruin a target's income-generating opportunities.

It is important to understand that at a broader level microaggressions affect patient safety and the healthcare workforce. The impacts on learning and work, health and illness (including traumatic stress and depression[18]) can have major detrimental effects on individuals and workplaces.[13] Harmful outcomes on healthcare professionals include job dissatisfaction, suboptimal care practices, major medical and medication errors and decreased patient satisfaction with medical care.[17] Further, microaggressions are harmful to the organisation, to those who suffer from them and to society. They reflect unconscious bias.[11] The societal price of microaggressions is the potential harm of the already fragile health workforce pipeline.[13]

In summary, microaggressions are an intrinsic (although regrettable) part of everyday general practice communities. They are damaging to individuals, have implications for patient safety and impact the healthcare workforce. As such, action must be taken.

Continuing professional development

Emergent literature supports the prioritisation of education and the development of strategies to address microaggressions. These interventions are based around the encouragement of all staff to take action, to learn strategies, and to create organisational accountability.[17] Some relate this essential step to professionalism;[13] others to achieving equity and inclusion in the workplace and workforce.[19]

There are several educational opportunities to spotlight microaggressions, foster insights and open discussions. It will be important to provide a potential trigger warning ahead of any of the suggested educational activities, and to provide a range of independent support options for participants to reach out to, such as Lifeline (phone 13 11 14) in the Australian context.

A common educational approach adopts mnemonics. For example, the VITALS mnemonic outlines one process towards speaking up about microaggressions:[20]

- **V** – Validate your own feelings and experiences
- **I** – Inquire to obtain more information
- **T** – Take time to mirror or reflect what the other is saying or emoting
- **A** – Assume the best but understand the need for clarity
- **L** – Leave opportunities for follow-up
- **S** – Speak up on behalf of others.

Another mnemonic is O^3 as a teaching tool for focused facilitation around microaggressions:[21]

- **O** – Observation of a fact 'I noticed that… ')
- **O** – Opinion ('I am concerned because…'; 'That makes me think/feel…')
- **O** – Open-ended inquiry ('Tell me about…')
- Conclude with suggestions ('Next time, consider…').

Fostering bystanders to become allies[19] is a major consideration in the general practice setting. Continual connections and engagement are necessary to build trust with targeted individuals. Personally, this requires choosing justice over remaining silent.[22] At the organisational level, practices can encourage and foster allyship through the PEARLS mnemonic:[23]

- **P** – Partnership
- **E** – Empathy
- **A** – Analogy
- **R** – Respect
- **L** – Legitimation
- **S** – Support.

The effect of being an ally to a targeted individual is articulated beautifully by 'Karen':

> *Can I share with you my uncertainty about a microaggression (that) I experienced, or will you come down like, 'Yeah, it was really not that bad, you know they didn't intend that'? Can I share with you my uncertainty about a microaggression (which) I experienced from you? Can I be angry about oppression? … it's justified – but is it tolerable to you? … Will you support that truth? The more I trust somebody, the less I have to package it.*[22]

Beyond the practice setting, the GP Colleges or associated professional organisations could integrate training in microaggressions as part of continuing professional development (CPD) for greater systemic change. One approach, using a flipped technique of pre-work, in-session, and post-work,[24] is suggested here. In the pre-work, ask CPD participants to read a selected article on microaggressions in the primary healthcare settings from the growing literature on the topic, then contribute through an anonymous survey one example of a microaggression that they have been privy to (personally or organisationally), across the range of '-isms' (racism, ageism, sexism etc). During the session, these further deidentified collated experiences can be used for small group work to identify the microaggression, the potential impact on the target, and suggest strategies for bystander interventions. To further reinforce and in paired activities, role play could then be considered. The scenarios used to open this article, or similar, can be run as a role play in a small group activity. For a microaggression to have increased impact, run with one participant playing the perpetrator (the new colleague),

one playing the targeted recipient (the experienced colleague), an ally and the remainder as bystanders (eg human resources or the practice owner, practice manager and other colleagues). However, as Acholonu et al[23] highlight, it is important to discuss with session facilitators what strategies they might use to engage participants who are 'non-believers' or who feel personally attacked or defensive during these exercises, so that they are well-prepared for any situation. One option is to use the VITALS or O^3 mnemonics in that context. It will also be important to debrief participants following such a session, asking collectively what went well, what did not, and self-reflections of discomfort in addressing the microaggression. The post-work might ask participants to self-reflect and consider ways that they might respond to a microaggression in the general practice setting, selecting one from a range of provided scenarios different from the ones already worked through in the CPD session, to reinforce and apply their new knowledge and skills to a different scenario.

A final necessity to help spotlight microaggressions in the general practice setting is for individuals to keep their Equity, Diversity and Inclusion training up to date.

Conclusion

It is important to identify all forms of microaggressions and the impacts they can have in the workplace, not only on the target, but in the workplace itself. The first step in addressing microaggressions is to recognise that they exist[4] and to listen to those who flag that microaggressions are taking place. The second step is to provide education to develop skills to disrupt microaggressions and to foster bystanders in becoming upstanders (allies).[17] Alongside this, it is important to improve safety for targets and allies through systems of organisational accountability. Future research might point to an analysis of microaggressions in Australian general practice settings. What is the prevalence? What are the characteristics? How is this identified and managed?

Please reach out to a safe person or professional support organisation such as Lifeline (phone 13 11 14) if any content in this article has been personally distressing.

Key points

- Microaggressions communicate hostile, derogatory or negative messages to the target persons, whether intentionally or unintentionally.
- The main types of microaggressions are microassaults, microinsults and microinvalidations. Environmental microaggressions can also take place.
- The four key players are the protagonist, the target, bystanders and allies.
- Microaggressions affect workforce stability when supporters and bystanders normalise the attacks and can impact patient safety.
- Professional development is important to raise consciousness and to foster allies.

Authors

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