AAIM Perspectives

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Microaggressions and Resiliency During Residency: Creating More Inclusive Environments

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Based on a true experience during residency:

Female Attending Physician: “So, how was the rotation for you two?”

Male Resident: “It was great! I learned so much.”

Female Resident: “I had a good experience too, but there were a few times where I felt left out.”

Female Attending Physician: “What do you mean?”

Male Resident: “Really? I didn’t even notice that.”

Female Resident (to Male Resident): “Did you notice how our senior resident treated me differently than you? Did you hear him tell me to be a good girl and pick up food and drinks for the team in the morning? That I would be better at these things than you because I’m naturally more nurturing and patient? And women are good at that stuff?”

Male Resident: “It’s no big deal— that’s just the way he is.”

Female Resident (to Female Attending): “What do you think?”

Female Attending Physician: “Yeah, that’s too bad. I’m sorry that happened to you. But— what can I say— boys will be boys. Try not to take it to heart.”

Female Resident: (Stunned silence): “Okay.” (and retreats back to work)
MICROAGGRASSIONS

Microaggressions Are Ubiquitous in Residency Programs. What Are They?

The term “microaggression” was coined by psychiatrist Chester Pierce, MD, in 1970,1 and was further developed and popularized by psychologist Derald Sue, PhD, in 2007.2 Microaggressions are “brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership.”2 There are 3 types of microaggressions: microassaults, microsights, and microinvalidations. Microassaults are conscious and deliberate actions or slurs against marginalized groups and most closely resemble blatant discrimination. For example, a senior resident might ask an intern: “Why can’t you people ever adjust easily to misfortune or change?”2 In contrast, microinsults and microinvalidations are subtle and thought to be unconscious. Microsights are verbal and non-verbal communications characterized as being insensitive, rude, and demeaning to a person’s identity. A microsight might include: “Are you a real doctor? You look like a child!” Microinvalidations are communications that exclude, negate, and/or nullify a person’s experience as a person of color.2 One example might be to promote “All Lives Matter” (during the “Black Lives Matter” movement).7 Though race/ethnicity is often considered the target of microaggressions, they can also be aimed at a person’s gender, sexual orientation, religion, or other marginalized status.2 All microaggressions are particularly harmful in medicine and can interfere with patient care and the professional interactions and development of resident physicians.

In medical school, microaggressions occur frequently. In one cross-sectional study of 759 medical students, 61% reported experiencing at least one microaggression weekly based on gender, race/ethnicity, and age.5 Though the specific incidence of microaggressions is largely unknown among residents, microaggressions are consistently reported among all trainees (medical students, residents, fellows) and attendings in different medical specialties (e.g., 72% in obstetrics-gynecology, 65% in emergency medicine, and 69% in plastic surgery).5,7 To illustrate, in obstetrics-gynecology, where most residents are women, one physician reported that male staff, patients, and family members assumed she was not a physician because she was female.5 In a study of microaggressions in emergency medicine, a trainee who identified as being LGBTQ+ experienced disparaging comments about LGBTQ+ patients in the emergency room (from both patients and staff). In addition, a surgical resident noted that their career commitment was called into question by faculty after having multiple children during residency.7

Residents who are underrepresented in medicine often experience racial discrimination and microaggressions; they often feel seen as “other” within their training programs.8 These residents may feel they cannot bring their culture or identity to the workplace. They may endure microaggressions related to being perceived as outsiders (invalidation), mistaken for nonmedical staff (status leveling), or receive messages that they are indistinct from other residents of color (failure to differentiate).9,10

The consequences of microaggressions are significant. Microaggressions can negatively affect physical and mental health.11 They are associated with higher rates of depression, psychological distress, and physiological stress with increased levels of the stress hormone cortisol.12 Though data are limited on the effects of microaggressions specifically among residents, there is a positive association with depressive symptoms among medical students.4 Over time, microaggressions can lead to burnout13,14 which can further exacerbate depression and fatigue, contribute to failed interpersonal relationships, and increase the risk of suicide.15 Furthermore, microaggressions can lead to worse job satisfaction, increased turnover, lower quality patient care, greater medical errors, and inhibit professional growth.15-17

Gradually, these consequences erode the health care system. When burned-out physicians leave the health care system, organizations are forced to recruit others which requires substantial time and financial resources.18,19 Efforts to hire new physicians can disrupt patient care and health care access,20 further exacerbating health inequities. Furthermore, high turnover can counter efforts to improve diversity, equity, and inclusion (DEI) within institutions, particularly when people from diverse backgrounds leave due to a lack of workplace inclusivity and support.14

Resiliency

Resiliency is defined as an “ability to recover from or adjust easily to misfortune or change.”21 Typically, a
person encounters a defining event or external stressor such as a microaggression that triggers vulnerability and leads to a reaction that reflects their culture, community and systemic structure, personal traits, and family. This reaction serves as the “source of resilience,” which helps build hardiness and brings about benefit finding, thriving, and post-traumatic growth. Ultimately, resilience leads to positive adaptive strategies which include the “Seven Cs of Resilience”: competence, confluence, control, connection, contribution, character, and coping.

Qualities of resiliency (persistence, self-preservation, and coping) are important when a person encounters daily microaggressions and can prevent burnout and improve mental well-being. In a national survey of 5,445 physicians, West et al. found that resilience and burnout have an inverse relationship. However, even the most resilient physicians had substantial rates of burnout. For example, emergency medicine physicians had the highest resilience scores but also the highest level of burnout. This correlation underscores the ongoing challenges inherent in promoting resiliency, establishing coping skills, and supporting well-being.

The residency training period is an opportunity for trainees to nurture resilience and reinforce positive coping strategies. While stress is essential in building resilience, developing resilience is hindered when stress is frequent and prolonged (e.g., from microaggressions) and lacks protective factors such as supportive relationships. The most common barriers to building resilience are social isolation, inadequate time and space to process negative emotions, overexposure to stressful events, humiliating experiences, and poor work-life balance. Residency training encompasses all of these barriers with limited opportunities available to promote resilience. Unfortunately, residency training programs have traditionally relied on residents already having established their own capacity for resilience in advance.

Understanding the negative impact of the challenges residents encounter, the Accreditation Council for Graduate Medical Education (ACGME) revised its Common Program Requirements in 2017 to ensure that all residency and fellowship training programs address physiological, emotional, and physical wellness to combat burnout among its trainees. Since then, training programs have implemented a variety of wellness initiatives that include activities such as retreats and group activities. Currently, the data on which activities are most helpful is inconclusive. Nevertheless, some have argued that an emphasis on wellness is not enough; instead, programs should develop and implement resiliency initiatives to counter the effects of burnout more effectively. Resiliency initiatives will be even more effective if they also acknowledge the role of microaggressions in burnout and provide strategies to combat microaggressions.

### Practical Solutions

Current strategies to minimize resident burnout often include organizing and implementing wellness activities in residency programs. These activities, which may have value, usually include lectures on wellness and/or stress management, informal social events, and mindfulness-based practice activities. However, in an unsupportive environment or an environment in which wellness is emphasized over resiliency, residents may not develop and nurture the necessary long-term coping strategies. Wellness initiatives may help residents cope with negative situations in the immediate time frame, but they likely fail to help them learn to process their emotions when they reoccur. Only a few residency programs initiate resiliency activities. In a review article on residency wellness programs, only seven of the 24 programs (29%) evaluated had a resiliency curriculum. None of these programs specifically addressed the role of workplace microaggressions in developing burnout. Wellness programs can (and should) incorporate resiliency initiatives to address rampant microaggressions.

One strategy to build resiliency in a residency program is to provide training on how to address future microaggressions and how to advocate for others. Noted approaches include Kimberly Manning, MD’s Five Ds Upstander Training, the A.C.T.I.O.N framework, and the Triangle Model. In these frameworks of action, witnesses are taught to advocate for others through a non-confrontational approach. In the 5Ds Upstander Training, people are encouraged to “direct, distract, delegate, delay, and display discomfort” when facing microaggression as an active bystander. In the A.C.T.I.O.N framework, people ask clarifying questions and state that what was observed was problematic. The Triangle Model considers the different perspectives of the recipient (action), the source (assist), or a bystander (arise) when a microaggression occurs. Residents may feel supported knowing their colleagues and supervisors can be influential allies in addressing microaggressions.

High-quality mentorship may also help. Mentor-mentee encounters represent an added safe space for a resident to disclose microaggressions and discuss how they affect their physical and mental health. Mentors can support mentee ability to develop resilience. For example, the Mentorship and Professionalism in Training (MAP-IT), a humanistic training program, has been shown to improve resilience and burnout in surgical residents and other medical professionals.

Additionally, residency program training on the role of discrimination and structural racism in medical decision-making can enhance understanding of the historical context that fuels implicit bias. Implicit bias and racism negatively affect clinical decision-making and are drivers of health disparities. Studies show...
anti-racism training can improve understanding of racism in health care and increase comfort in discussing its effects on poor health outcomes. An inclusive environment recognizes the harms of microaggressions and provides the support needed so diverse trainees can successfully develop professionally and personally. Program directors should have a diverse pool of associate program directors and chief residents to support short- and long-term goals to improve DEI within their residency programs. Program directors can also consider a specific DEI chief resident because of that individual’s unique, influential role in residency programs.

Changes in work environment culture will take time and active engagement from residency program directors, faculty, and staff. Currently, many trainees express fear in reporting microaggressions due to retaliation. One approach to addressing this barrier is implementing a confidential reporting system in place. University of Illinois College of Medicine Department of Medicine implemented this system in October 2021 and has discovered 25 incidents reported over 18 months. So far, most reported occurrences have been nonspecific events related to gender bias and ageism. However, a selected leadership team reviews each incident to determine the need to escalate. Additionally, the internal medicine residency program developed a training curriculum focused on microaggressions through funding from the American Board of Internal Medicine (ABIM) Foundation. It is designed for trainees, faculty, and staff and incorporates the reported, anonymous microaggression incidents to promote discussion. This project will track changes in measures of well-being and burnout of trainees, faculty, and staff in addition to diversity engagement to evaluate workplace culture over a two-year period. Furthermore, implementing more substantive reporting of microaggressions has the potential to track repeat aggressors if a person is empowered to report full details without being subjected to retaliation. Leadership can hold people accountable for unprofessional behavior. Such methods should be formally evaluated.

While some college and graduate schools have made bias reporting tools available recently, there is no literature on their effectiveness or any other potential consequences.

Finally, implicit bias reduction trainings may create inclusive work environments. For example, the Bias Reduction in Internal Medicine (BRIM) training provides evidence-based strategies to address components of implicit bias in the workplace, including microaggressions. University of Wisconsin reported that they increased their faculty hiring of women and individuals underrepresented in medicine after one training. Ongoing research will reveal its ultimate impact on promoting diversity in academic medicine fueled by behavioral change.

**CONCLUSION**

Microaggressions are frequently encountered in residency training. They can lead to burnout and interfere with patient care. Resiliency initiatives, in addition to wellness initiatives, may combat workplace microaggressions and minimize their harm. Residency program directors and leaders at academic institutions can work closely with trainees, faculty, and staff to implement long-term, sustainable strategies to improve workplace culture and promote inclusivity.

**References**

12. Spanierman LB, Clark DA, Kim Y. Reviewing racial microaggressions research: documenting targets’ experiences, harmful


