

No One Size Fits All: A Qualitative Study of Clerkship Medical Students' Perceptions of Ideal Supervisor Responses to Microaggressions

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Abstract

Purpose

This study explores medical students' perspectives on the key features of ideal supervisor responses to microaggressions targeting clerkship medical students.

Method

This single-institution, qualitative focus group study, based in an interpretivist paradigm, explored clerkship medical students' perceptions in the United States, 2020. During semistructured focus groups, participants discussed 4 microaggression scenarios. The authors employed the framework method of thematic analysis to identify considerations and characteristics of ideal supervisor responses and explored

differences in ideal response across microaggression types.

Results

Thirty-nine students participated in 7 focus groups, lasting 80 to 92 minutes per group. Overall, students felt that supervisors' responsibility began before a microaggression occurred, through anticipatory discussions ("pre-brief") with all students to identify preferences. Students felt that effective bystander responses should acknowledge student preferences, patient context, interpersonal dynamics in the room, and the microaggression itself. Microassaults necessitated an immediate response. After a microaggression, students preferred a brief one-on-one

check-in with the supervisor to discuss the most supportive next steps including whether further group discussion would be helpful.

Conclusions

Students described that an ideal supervisor bystander response incorporates both student preferences and the microaggression context, which are best revealed through advanced discussion. The authors created the Bystander Microaggression Intervention Guide as a visual representation of the preferred bystander microaggression response based on students' discussions. Effective interventions promote educational safety and shift power dynamics to empower the student target.

Diversity is an essential characteristic of successful institutions.¹ In medicine, diversity enhances educational experiences in training, promotes social equity, and improves patient health outcomes.²⁻⁴ Institutions with an advanced understanding of the importance of diversity move beyond mere demographic representation of multiple social identity groups to drive institutional culture toward meaningful inclusion where diversity is prioritized as fundamental to institutional excellence.¹ However, medical institutions fall short of these ideals, with learning environments that are not inclusive of diverse individuals. In particular, students

of color experience biases in assessment and advancement, decreased social capital, racism, and microaggressions that negatively impact their learning and performance.⁵⁻⁸ Despite harmful consequences of frequent racial and gender microaggressions in medicine, a gap remains in our collective understanding of how best to address microaggressions to improve the clinical learning environment.⁹⁻¹¹

Microaggressions are verbal, behavioral, or environmental indignities that communicate hostility or negativity—whether intentional or unintentional—toward a target's identity(ies).¹² Patients, providers, peers, and the learning environment itself are all common sources of microaggressions, which pervade the clinical learning environment to the detriment of learners, providers, and patients.^{9,10,13-15} Sue and colleagues characterized 3 types of interpersonal microaggressions: microassaults, microinsults, and microinvalidations^{6,12} (see Table 1). Microassaults, the most egregious form, are verbal or nonverbal attacks that offend the target (e.g., patient refusing care from minority providers

due to race).¹⁶ Microinsults are subtle remarks which demean the target, even if unintended by the perpetrator (e.g., calling a female doctor a nurse). Finally, microinvalidations negate or dismiss the target's lived experience (e.g., saying that minority students these days are too sensitive to microaggressions). Microaggressions may cause both psychological and physiological distress. They are associated with depressive symptoms, anxiety, and alcohol use and may alter diurnal cortisol secretion.¹⁷⁻¹⁹ Medical students report that microaggressions trigger and exacerbate racial/ethnic stereotype threat, a process in which fear of fulfilling negative stereotypes about one's group results in lower performance.^{10,20,21} Stereotype threat, in turn, triggers negative emotions and increases students' cognitive load, and is associated with lower core clerkships grades.^{10,22}

We use the terms "source," "target," and "bystander" to refer to the microaggressor, recipient of the microaggression, and witness to a microaggression, respectively.²³ Critical race theory (CRT), with its focus on

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Table 1
Microaggression Focus Group Scenarios^a

Microaggression type	Definition ^{6,12}	Focus group scenario (alternative scenario)
Microassault	An explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the target victim through name-calling, avoidant behavior, or purposeful discriminatory actions.	You are a male Latinx (African American) medical student doing a rotation in the emergency department. You and your attending walk into the room of a patient who was found by EMS to be wandering the streets and agitated. As you enter, you introduce yourself to the patient who is writhing on the gurney. She says to you, "I don't want no illegal alien (Black) doctor."
Microinsult	Subtle snubs, frequently unknown to the perpetrator, that clearly convey a hidden insulting message to the target race, gender, or other identity.	<p>You are a female Asian American student on your surgery rotation. You walk into the room of a patient whom you have been helping to care for, for the last 3 days. As you enter the room with your male attending, you tell the patient that he will be discharged today. After asking if he has any questions, the patient responds, "I don't have any questions, I am just sad that I won't get to see your pretty face tomorrow when I wake up."</p> <p>You are a male medical student with spastic paraplegia of the legs (Sikh student) who walks around with a cane (dastaar or turban). During the course of your internal medicine rotation 1 week 3, different patients made comments to you about the way you walk (your turban) in front of the team. As you are rounding with your team 1 morning, a patient says to you, "I have a friend who has a gimpy leg and walks like you." ("I have a friend who also wears a scarf on his head.").</p>
Microinvalidation	Communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of another (the target).	You are a White fourth-year female medical student doing an inpatient medicine sub-I. After multiple interactions with a patient, you realize that every time you enter the room, he directs all of his questions to the male third-year medical student despite the fact that as the sub-I, you are acting as his primary provider. When outside of the patient room, you mention this frustration to the team in passing. The third-year medical student replies, "I don't know, I did not notice that, and I don't think it is that big of a deal."

^aThe authors created focus group scenarios representing 1 of the 3 major types of interpersonal microaggressions.^{6,12} To explore consistency across microaggression types, the authors created 2 similar microassault and microinsult scenarios by manipulating the student identity targeted by the source.

power, offers an important theoretical lens through which we explore the impact of microaggressions and effective bystander responses.^{24,25} CRT highlights racism as the norm in American society, recognizes how power mediates racially charged interactions, and acknowledges that people can have multiple marginalized identities that intersect and compound with racism (e.g., sexism, classism).²⁴ Because of their sometimes subtle and context-dependent nature, microaggressions may be interpreted variably by different individuals.²⁶ Bystanders may simultaneously be witnesses to and impacted by a microaggression.²⁷

We prioritize the perspective and interpretation of the target as the person most likely harmed by the microaggression. CRT acknowledges the intersecting challenges students face navigating racialized educational hierarchies. When patients commit microaggressions against students, students hold intersecting vulnerabilities as they are simultaneously the microaggression target and low in educational status compared with bystander supervisors; students may also be caretaker for the patient and feel professionally obligated to continue caring unless a team member intervenes.

While faculty atop the medical hierarchy may be positioned well to advocate for students, they often meet microaggressions with inaction when learners most need bystander support.⁹ Many faculty describe that their increasing awareness of bias and discrimination prompts feelings of "walking on eggshells," with increased anxiety about doing or saying the wrong thing and being labeled as racist or sexist by learners.^{28–30} Unfortunately, this discomfort and fear can result in failing to meet learners' needs and thwart efforts toward inclusive culture.

A variety of techniques for bystander interventions on microaggressions have been proposed, including Sue's microinterventions, Ackerman-Barger's ARISE framework, Wheeler's 12-tips, and others.^{6,23,31–37} These techniques generally entail recognizing a microaggression, deciding whether or not to respond, and employing various response techniques in the moment.^{23,32,37} Though these approaches provide general guidance for responding to microaggressions targeting learners, there is a need for evidence-based understanding of the impact of responses and recommendations to maximize the effectiveness of responses for learners. The emotional, cognitive, and physiological impact of microaggressions on learners, as well as the multifactorial considerations underpinning a decision of when and how to respond to a given microaggression, prompt questions about how educators understand learners' perspectives on optimal bystander interventions.

The purpose of this study is to explore students' perspectives on how bystander supervisors should respond to microaggressions on clinical clerkships. The research questions are: (1) What are student perspectives on key considerations for a faculty member responding to a microaggression targeting a student? (2) What are the key features of an ideal supervisor response to a microaggression? and (3) How does the ideal response differ by type of microaggression?

Method

Design

For this qualitative focus group study, based in an interpretivist paradigm,

we employed the framework method of thematic analysis to explore medical students' perceptions about supervisor responses to microaggressions from patients targeting clerkship students in the United States, 2020.³⁸ This year was notable for significant national social unrest because of racial and ethnic inequalities; our data are interpreted within this context.^{39,40}

Our research team included 1 South Asian medical student, 1 Black resident, 4 faculty (2 White, 1 Native American and White, 1 Latina). All team members were from the University of California, San Francisco (UCSF) School of Medicine, with academic interests in the experience of minoritized learners. All faculty members work directly with medical students.

The UCSF Institutional Review Board approved the study as exempt (IRB #20-29884).

Setting and participants

The study site was UCSF, a state public institution with 3 core teaching systems (quaternary university system, public safety net hospital, and veterans' affairs medical center) and multiple community-based affiliates. All third- and fourth-year (clerkship years) medical students during March 2020 were eligible to participate. We used convenience sampling, relying upon the diversity of the medical student body (33% underrepresented in medicine, 53% female) to ensure diverse participants. We recruited students through 4 weekly listserv emails to the classes of 2021 and 2022. The email invitation directed interested students to the Qualtrics web platform to enter their demographics, email address, and availability. We invited all interested students to a focus group. Focus group participants received \$20.

Data collection

During semistructured focus groups, participants discussed 4 microaggression scenarios representing the 3 major types of interpersonal microaggressions (see Table 1).^{6,12} Scenarios depicted a student microaggression target and faculty bystander in an inpatient or emergency department setting. The research team designed scenarios based on literature review and team members'

lived experiences. To explore consistency across microaggression types, we created 2 similar microassault and microinsult scenarios by manipulating the targeted student identity. The moderator (P.K.M.) began all focus groups by defining microaggressions and informing students that the purpose was to create faculty trainings on how to respond to microaggressions. The moderator and co-facilitator (J.L.B.) underwent facilitator training before conducting a pilot focus group with 4 UCSF Medicine residents ineligible for participation. Authors then revised the focus group guide to improve clarity and reduce redundancy before formal data collection began. The final guide is Supplemental Digital Appendix 1, available at <http://links.lww.com/ACADMED/B157>. The co-facilitator took notes documenting key ideas and interparticipant interactions during focus groups. We inverted scenario order for the final 3 focus groups to balance discussion of each case. Data collection ended after all interested and available students participated. By the final focus group, no new major ideas or response strategies were discussed, indicating sufficiency of themes and data collected.⁴¹ All groups were conducted and recorded over Zoom, professionally transcribed, and deidentified before analysis.

Analysis

Four researchers (J.L.B., P.K.M., M.T.O., K.E.H.) independently read and performed open coding of 3 transcripts. The research team then met to discuss their proposed codes, developed an analytic framework, and created a single codebook. Next, 2 of 5 researchers (J.L.B., P.K.M., M.T.O., K.L.L., K.E.H.) separately coded each transcript and reconciled discrepancies through discussion. Interviews were coded using Dedoose Version 8.0.35 (Los Angeles, California). After sorting coded excerpts by microaggression scenario, we synthesized excerpts by code for each scenario. We charted each synthesis into the final framework matrix which held microaggression scenario by code (column by row) using Microsoft Excel Version 16.44 (Redmond, Washington). All researchers participated in the final interpretation and summary of the data. We indicated participants' self-identified race/ethnicity alongside their quotations.

Reflexivity

The research team frequently discussed our reflections on students' responses and how our personal experiences with microaggressions juxtaposed with participants'. This project was conceptualized after 2 team members (J.L.B., M.T.O.) witnessed a microaggression against a clerkship medical student; the attending (M.T.O.) responded to the microaggression, and the entire clinical team later debriefed the experience. The student gave feedback that extensive reflection after a microaggression was not helpful.

Credibility

After the analysis, we emailed all participants a draft of the manuscript results and discussion for their feedback on whether the presented results felt consistent with their focus group discussions and clinical experiences. Ten participants responded: all agreed that the results and discussion accurately represented their focus groups. Three gave minor text edits, and one participant clarified her quotation and race/ethnicity.

Results

Forty-five students responded to our survey invitation; 44 were invited (1 was unavailable for any focus group times offered). Thirty-nine students participated in 7 focus groups, with 5 to 7 students per group. Focus groups lasted an average of 86 minutes (range: 80–92). Participants had a range of intersecting social identities (see Table 2). Fifteen (38%) participants identified as Asian, 12 (31%) Black, 5 (13%) Latinx, 17 (44%) White, 1 (3%) Native American, and 1 (3%) Middle Eastern. Thirteen (33%) participants identified as men, 25 (64%) women, and 1 (3%) nonbinary, and 15 (38%) as LGBTQ. As participants discussed the provided scenarios, they also reflected on their own experiences with microaggressions in the clinical workplace. Findings below represent students' perspectives based on the scenarios and their lived experiences.

Within focus groups, students seemed to defer commenting until after those who self-identified with the identity targeted by the microaggression case responded (men deferred to women for gender-based microaggressions; White students deferred to students of color

Table 2

Descriptive Demographics of Third- and Fourth-Year Medical Student Focus Group Participants at One Medical School, 2020

Participant demographic	Number (%)
Total number of participants	39 (100)
Asian ^a	15 (38)
Black	12 (31)
Latinx	5 (13)
Middle Eastern	1 (3)
Mixed	9 (23)
Native	1 (3)
White	17 (44)
Underrepresented in medicine ^b	15 (38)
Men	13 (33)
Nonbinary	1 (3)
Women	25 (64)
Heterosexual	23 (59)
LGBTQ	15 (38)
Prefer to not answer	1 (3)
Third-year medical student	20 (51)
Fourth-year medical student	19 (49)

^aRace/ethnicity categories add up to more than 100% because respondents could select as many racial/ethnic identities as they felt applied to them.

^bStudents who identify as Black/African American, Latinx, and Native were categorized as underrepresented in medicine.

for race-based scenarios). We did not identify differences in responses based on participants' sexual orientation, though none of the scenarios addressed this topic.

Overall, students endorsed that effective supervisor responses began before microaggressions occurred. Results below describe 2 themes: Student perceptions of bystander considerations and supervisor action. For the first theme, we capture students' perceptions in 3 subthemes. In response to a microaggression, students felt that supervisors should consider the *student's preferences*, which ideally were gathered through anticipatory discussions ("pre-brief") with their faculty supervisors, the *patient's context*, and the various *interpersonal dynamics* in the room. For the second theme, *supervisor action*, students described ideal supervisor responses *during the microaggression*, when it was appropriate to *bear witness*, or defer response until outside the room, and, finally, effective responses *after the microaggression*. These results

are detailed below. Quotations include participant number, self-identified race/ethnicity, and gender.

Student perspectives on supervisor considerations for an effective response

Student preferences: Preparing for microaggressions through a "pre-brief." Because students brought their own identities, experiences, and preferences, their desired responses to microaggressions differed (see Table 3). Participants cautioned against extrapolating any one student's preferences onto other students.

There is no one size fits all. There is no standard operating procedure.... Doesn't mean that we know what intervention would best suit the situation or minimize the harm to those that are targeted. I think in some ways it's phrased as humility. (P37, Black/Middle Eastern woman)

One solution to this concern proposed repeatedly across focus groups was to pre-brief. We use pre-brief to refer to discussion at the onset of working together which allowed the learner and supervisor to prepare for potential microaggressions. Many students believed that the most important contributor to an effective bystander response was whether the supervisor had pre-briefed.

Attendings should be having these conversations with their students in advance ... at the beginning of a rotation and having a plan for how to address microaggressions that they recognize, but also ... if there are microaggressions they don't recognize, how the student can feel empowered to communicate that. (P19, Black man)

Students felt that pre-briefing allowed them to inform the supervisor of their preferences regarding responses to microaggressions and promoted bystander responses that were actually supportive for them. By discussing microaggressions in advance, supervisors signaled to learners that they prioritized students' psychological safety. Participants emphasized that the supervisor should pre-brief with all learners, not simply those who appeared likely to be targeted with microaggressions, which might make students feel singled out. There was not consensus about whether the pre-brief should happen one-on-one, as a clinical

team, or by email. Asking students for their preferences shifted power from the attending to the student and conveyed respect that the student knew what would best address their needs.

Participants noted that while attendings are content experts for medical care on the team, they may lack comparable expertise for responding to microaggressions, and that the uncomfortable shift from expert to novice might be a source of inaction for attendings. They may also be unfamiliar with the correct cultural terminology to educate patients. Referring to the *dastaar*, the customary Sikh headwear, one student said:

I would feel if that were not my own culture, I might as an attending have a hard time being like, "Oh, I'm going to explain what's going on with this student for everyone," because that would also feel very strange for me to do that. (P21, White woman)

In this case, a pre-brief was felt to be especially important to inform attending response.

Patient context. Students identified clinical context and medical acuity as critical considerations to direct the nature and timing of a response to microaggressions. For instance, attempting to reason with an acutely agitated patient was unlikely to deescalate a microaggression. A microaggression from an ill or confused patient did not absolve the supervisor from responding, but rather, changed the timing and characteristics of the ideal response.

If they are acutely, critically ill.... I think it would be more okay with me personally to hold off on a comment about this for a time where they're more stable. (P12, Chinese American woman)

Students wanted to be thoughtful about the timing of an ideal response in the context of a patient's course and did not want to deliver harsh responses to patients soon-to-be discharged or with upcoming procedures, so as not to dissuade them from seeking future care.

Interpersonal dynamics. The student-patient relationship was a key consideration in deciding how supervisors should respond. Participants acknowledged that every patient comes with their own identities, experiences,

Table 3

Student Perspectives on Key Considerations to Guide Faculty Responses

Considerations	Description	Example quotations
Student preferences	Identities, experiences, and preferences that students bring which impact their desired responses to microaggressions. This was best discovered through discussion at the onset of working together which allowed the learner and supervisor to prepare for a potential microaggression and discuss student preferences.	<p>"I think in a perfect world, the attendings would think about our intersectional identities, let us know that they're here to create a safe space for us and defend us if anything were to arise, and then be very open to asking for feedback or suggestions or just what we need." (P30, Nigerian American woman)</p> <p>"What I consider the most efficacious thing ... is something that's going to promote the learner's ... ability to be a learner, whether that's in terms of ability to provide patient care and engage in patient care and comfort and well-being." (P6, Chinese American woman)</p> <p>"I think also as this focus group has demonstrated; we all have very different experiences that influence how we want microaggressions handled. My response to one might be wildly different than someone else's just based on innumerable factors. I think that really speaks to the utility of connecting, ideally on day one of our rotation or whatever, by email, before the rotation starts." (P16, White woman)</p> <p>"I had one senior resident, [name redacted], who was amazing.... When she was coming on as a senior, she sent everybody an email, including a paragraph saying 'microaggressions are a real thing, I want us to talk about how you might want me to address this, if I see it happen.' And she sat down with each of us without meeting any of us previously and having no idea what we looked like.... And with that interaction, I had so much more trust in how she was going to address issues because she had even the vaguest sense of how I would feel about things." (P15, White/Asian American woman)</p>
Patient context	Clinical acuity, mental status of a patient, and whether they would soon be discharged or undergo a procedure.	"You have to also consider the context and that this is an acute ED visit and the patient's currently agitated. So having a patient go through that mental gymnastics of, 'Why am I saying this?' is kind of hard to do given the context." (P11, Latina)
Interpersonal dynamics	Student–patient and student–supervisor relationships and the associated relational dynamics between the various groups.	"If an attending doesn't respond, I lose faith in them. It's hard to be excited to work with them and trust them. They're not even willing to stick up for the student when something like this happens." (P32, African American man)
Attending	The identities, experiences, and knowledge that supervisors bring which impact the way they naturally respond to microaggressions.	<p>"My attending is saying something real wrong then I gotta say something to him, but he already said something to my patient and it made the whole situation worse. And it's a double burden, and you can't always assume that your attending's going to know what's the right thing to say. And then you're also educating the attending." (P31, Afrolatina)</p> <p>"Sometimes [the attending has] to switch into a mindset where [they're] going from, [I'm] the expert and I'm just checking what the student knows, to, okay, the student is the expert and now they're checking what I know." (P19, Black man).</p>
Microaggression	Consideration of the microaggression type and context in which the microaggression occurred.	<p>"I just want attendings to be careful. Always trying to take into account what the context is. Because I think that that potentially could be a slippery slope away from intervening and easier to come up with reasons to not intervene." (P19, Black man)</p> <p>"I think that the prior episodes should be taken into account, as well as the intent behind what the patient was saying, and any other communications that have happened between the attending and the student themselves." (P7, White man)</p>

Abbreviation: ED, emergency department.

and preferences that interact with students' (and other team members') identities. Students inferred patient intent from the type of microaggression. Microassault scenarios were largely viewed as an act of overt racism against the targeted student, whereas students considered context and intent for microinsults and microinvalidations. For instance, a patient's preference for one team member over another may not be perceived as a microaggression if a

provider of a concordant identity offered a source of comfort for a patient:

A patient's going to be more comfortable with a practitioner that matches their identity.... I can think of, as a Black patient, if there's a team and there's a Black person there, one person in that team.... I'm going to feel more comfortable directing my questions to that person. (P31, Afrolatina)

Some students preferred nonconfrontational responses because

they prioritized their patient alliance and felt that confrontation could complicate the student–patient relationship.

Supervisor action

Students asserted that effective supervisor bystander responses would protect and validate the student but should not necessarily aim to change the patients' beliefs. An effective response acknowledged the microaggression, promoted a safe learning environment,

provided allyship, demonstrated role-modeling, and, when necessary, let students escape harmful situations (see Table 4). Many, but not all, students wanted a response in the moment. Because there was no single response that satisfied all learners or scenarios, students felt that it was important for “Attendings to feel that they have multiple angles in their toolbox, both because the context is different each time, but also it takes sort of multiple attempts at different angles sometimes to get through to someone” (P9, White woman). After the patient encounter, students preferred brief one-on-one check-ins with faculty to acknowledge the microaggression and ask whether the student wanted space for additional reflection, or to debrief with the entire medical team, before doing either.

During the microaggression. Effective responses while still in the patient encounter were short, direct, and did not attack the patient. Examples of students’ proposed in-the-moment responses included: emphasizing the clinical value of the student, using humor, educating the patient, redirecting to focus on clinical care, clarifying roles, and setting boundaries. Students debated whether asking a patient to explain why they felt a certain way was effective, as this strategy risked prompting the patient to expound on racist beliefs. For microassaults, students wanted an immediate response or to pause the encounter to leave the room if the patient was clinically stable. If unable to leave the room due to clinical acuity despite a flagrant microaggression, students recommended that supervisors say a short, direct response and allow the student to step out. For other microaggression types perceived as less severe, some students preferred the supervisor to bear witness as described below, delaying active response until after the team left the encounter. Others cautioned against lack of response in the moment.

Bear witness. We use the phrase “bear witness” to refer to identifying the microaggression and intentionally deferring intervention. A provider may bear witness in the room by intentionally exchanging a knowing look with the trainee or discussing the microaggression later. However, unless a student had explicitly stated this preference, students

cautioned against not responding to microaggressions.

[Not responding] to me is kind of sounding like a problem. We’re okay with having tough skin and we’re okay with people ignoring the problem ... sounds kind of like that’s the same, like let’s just ignore it and move on. The whole issue is that we’re talking about microaggressions because they happen so often that eventually they break your thick skin. (P26, Mexican American woman)

After bearing witness, students considered a postencounter check-in critically important.

After the microaggression. Students deliberated whether the supervisor’s discussion of the microaggression after leaving the patient encounter should happen individually with the student or as a team. Most students preferred a brief private check-in to discuss whether further group discussion would be healing for the student. While some felt that validating emotions with the team was important, many worried that group discussion might invite an exhausting dialogue that could feel retraumatizing or performative, allowing others to express their emotions and appear as allies but not actually helping the student. Students felt it was imperative that attendings avoid forcing them to relive a stressful event that they did not want to process at that moment. Students subjected to a microassault or frequent microaggressions from a patient wanted their supervisor to propose the option of reassigning the student to a different patient. It was important for supervisors to clarify that reassignment was not a reflection of skill and would not harm student evaluations. Finally, some students recounted positive experiences returning to discuss the microaggression with the supervisor and patient when the patient was no longer confused or angry.

Discussion

This study describes medical students’ preferences for and experiences with faculty supervisor responses to microaggressions targeting clerkship students. Students rejected a simple one-size-fits-all response. Rather, they identified a variety of considerations which they felt faculty members should weigh in responding, including student preferences and microaggression context. Their favored bystander responses

represented strategies to shift decision-making power toward targeted students.

The Bystander Microaggression Intervention Guide (B-MIG, Figure 1) is a visual representation of the preferred bystander response from the perspective of our study participants. Participants recommended that supervisors ask all medical students for their preferences for responding to microaggressions at the onset of working together and to check-in again briefly with them after each microaggression. Students agree that all faculty supervisors should respond, even if briefly, to all microaggressions at some point. The B-MIG can be used as a response guide to scaffold personal or faculty development for responding to microaggressions; it cannot be a prescription because of the ongoing need to adapt responses to student and context. Supervisors can consider using the B-MIG as a guide to engage in team discussions around how to support one another in the event of a microaggression.

Bystander responses centered on students’ wishes can foster an environment of educational safety. Tsuei et al defined educational safety as “the subjective state of feeling freed from a sense of judgment by others such that learners can authentically and wholeheartedly concentrate on engaging with a learning task without a perceived need to self-monitor their projected image.”⁴² Implementing effective student-centered interventions to microaggressions may reduce stereotype threat and its associated cognitive and affective load.^{10,21,22} Reflecting on multiple participants who described a sense of trust and comfort from supervisor pre-briefs, we view the pre-brief as a critical tool to foster a more favorable learning environment for all. Because student preferences differ, a single strategy for responding to all microaggressions is unlikely to optimally support all students. Building on other bystander response literature, the recommendation to pre-brief best elaborates upon the work of Wheeler et al, specifically the recommendation to “establish a culture of openness and respect upfront.”^{11,32} In our limited experience implementing the pre-brief on our clinical teams, some students are unsure of their preferences regarding microaggression responses. Revisiting this discussion allows students to reflect on experiences with microaggressions

Table 4

Representative Example Quotations Illustrating Favorable Bystander Responses to Microaggressions, Grouped by Microaggression Type and Whether the Response Was During (Still in the Patient Encounter) or After the Microaggression

Microaggression type	Potential bystander responses
During the microaggression	
Microassault	<p>"Given that you haven't even tried to do anything yet beyond just introduce yourself, I think it's fine for them to both just leave the room immediately. I think I would want the attending to be like, 'Why don't we step outside for a second?' ... I would want the attending to pull me out of the room and just be like, 'Let's just check in for a second. How are you feeling? Do you even want to continue seeing this patient?'" (P19, Black man)</p> <p>"I definitely want this to be acknowledged in the room immediately as soon as possible ... rather than the attending, or me, or the students leaving the room, talking about it, and then attending later discussing it with the patient." (P34, African American man)</p>
Microinsult	<p>"I'm remembering a time when I was on an all-female team on medicine and the patient said something like, 'You're all so pretty,' as we were rounding. And my senior resident modeled, I think really effectively, what a response could look like in that moment. She actually got stony faced and a little bit cold and let a beat happen, didn't smile and say thank you, but then said, 'Yes, and we're taking really good care of you.'" (P24, Korean woman)</p> <p>"I don't think I personally would want anything to kind of happen in the patient room at that time. So more to just feel like someone realized that this was occurring and that acknowledgment that that isn't okay." (P13, South Asian woman)</p> <p>"When attendings use humor to teach patients, I find that very effective ... I personally, have found when attendings have used humor like, 'Oh, do you think this is high school? This is a hospital, come on now,' or things like that, have worked for me. And even though people have a laugh about that I think my interactions with those patients after that were more comfortable because of that humorous comment." (P36, Indian American man)</p>
Microinvalidation	<p>"To me it feels less important that we teach this patient how to be less sexist and more important that we teach the team how to be empowering of women. So to me, the most important thing the attending could say was, 'Wow, I noticed that too.' And just sort of this validation that that was the dynamic, because I think some gaslighting can happen where you're not even sure if what you're saying is true." (P39, White man)</p> <p>"I think I would want the attending to look out for it the next time and be like, 'Actually XXX is your provider. You should ask her.' It's just how I would want that." (P1, Asian American woman)</p>
After the microaggression	
Microassault	<p>"It is not only saying sorry or understanding that they might not understand the totality of the impact of the microaggression on the student, but asking in the future, 'How would you like me to address these types of things?' Because I think it varies depending on the student of what they would want the attending to do in certain situations." (P11, Latina)</p> <p>"I think it's valuable to have the attending then approach the student later on and just say either, 'I'm really sorry,' and just leave it at that. Because sometimes you don't want to reopen the wound or whatever, but address it and just say I'm sorry that happened." (P1, Asian American woman)</p>
Microinsult	<p>"I was on a team and the patient was an older gay man and every time I came in, he would ask me to sleep with him. I was stunned ... I said to him, my own self, I was like, 'Remember, that's not very appropriate. We're here to focus on your care.' And then afterwards ... the attending asked, 'I'm really sorry that that happened to you, is there anything I can do to be supportive? You seem to have handled it.' And I said, 'No, it's fine with me. This is not the first time he's said this to me.'" (P28, White-Black man)</p> <p>"I think it's a good idea for the attending to make a little bit of time when they go back and see the patient outside of the team setting to just also sit down and address that maybe they can go back to them like, 'It made me a bit uncomfortable when you called her that instead of her name. So next time just make sure to call her by Dr. Last name or whatever.'" (P35, Chinese immigrant woman)</p> <p>"I would be in favor of minimal debriefs, but multiple check-ins. Maybe not necessarily after every scenario, but I think if an attending or a senior resident can build a culture in which they check in regularly, every regular check in is an opportunity to just check in about what has been happening for you consistently, even if it's not done with the whole team regularly." (P14, Nigerian American woman)</p> <p>"I hate it when all attendings just jump to debriefing sessions right after a microaggression had occurred.... And I absolutely hate it when everyone was like, 'Oh let's congregate and talk about this. XXX, what did you feel in that moment?' I'm still feeling it." (P36, Indian American man)</p>
Microinvalidation	<p>"This feels like a very appropriate scenario for having a big team discussion, for going pretty hardcore on education. Yeah. Because, for me, part of our education, as future providers and as community members, would be to try to know how to address this behavior appropriately. And so, I think that it's totally normal to want the third-year medical student or any student or any attending to be educated about this." (P15, White/Asian American, woman)</p> <p>"I don't think I would want it to, I think repeatedly keep having it be a conversation because I think at some point it would take away from also just focusing on the learning and the patient care and the medicine aspect of things." (P13, South Asian woman)</p>

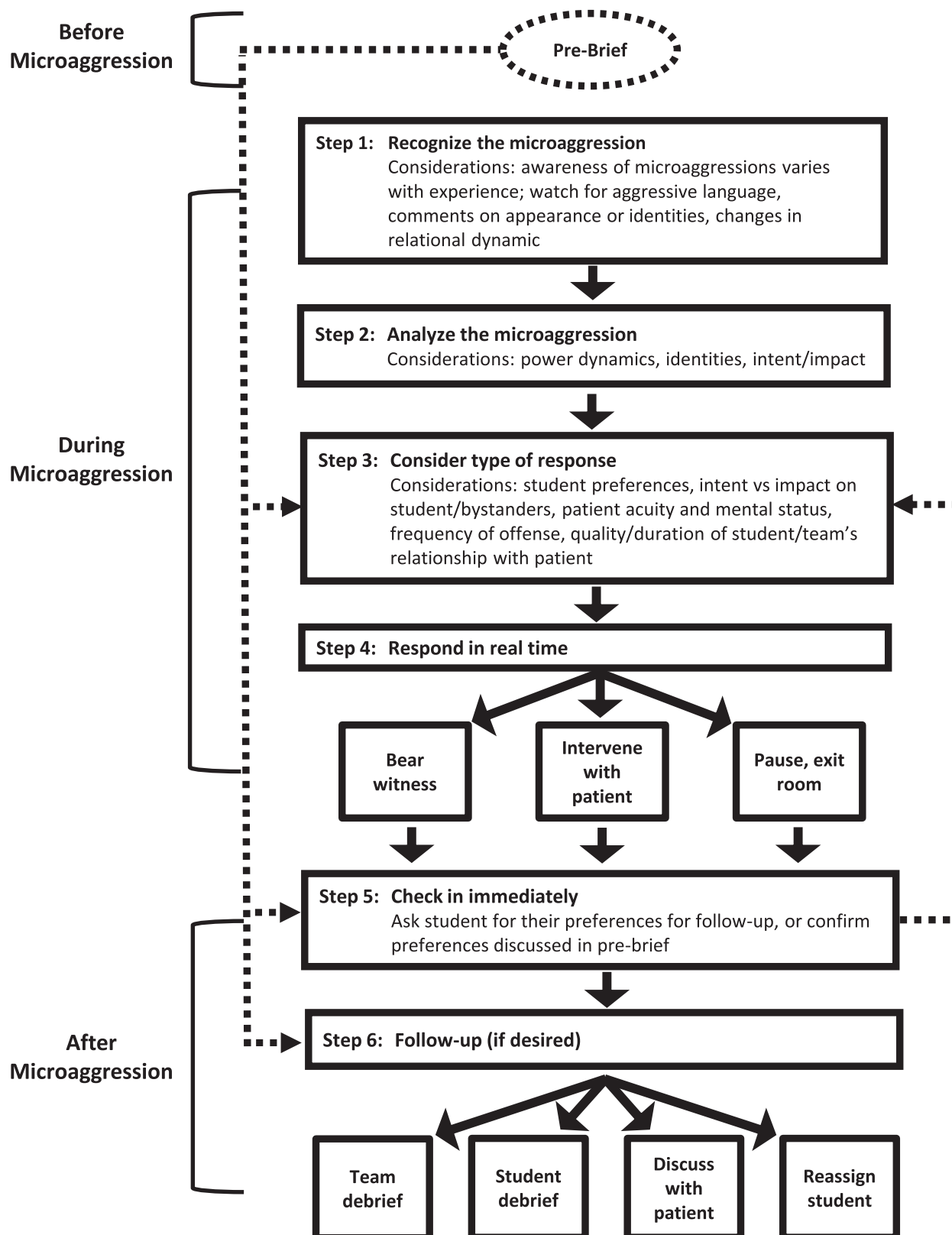


Figure 1 Bystander microaggression intervention guide.

and revise their preferences for future microaggressions. More work is needed to optimize the language, timing, and structure of the pre-brief.

Our participants' perceptions of ideal supervisor responses shift the bases of power from supervisors toward learners. French and Raven's 6 bases of power

(legitimate, expert, informational, reward, coercive, and reverent) constitute a useful framework to examine social power shifts.^{43–45} A supervising attending holds

legitimate power with authority over the medical student. Expert power is based upon what an attending is presumed to know, while informational power comes from the information that one shares with others.⁴⁶ A supervisor who pre-briefs and then enacts a student's wishes after a microaggression has treated the student as expert in their own experience of microaggressions and effectively transferred legitimate and expert power to the student. When students inform supervisors of their preferred microaggression response, they transfer informational power to facilitate supervisors' ability to be allies.^{37,46} By confirming that a student's decision to discontinue caring for a patient will not impact their assessment, supervisors can neutralize reward and coercive power. Supervisors who do not respond to microaggressions targeting students may lose referent power as students lose faith in them as role models. The suggestion that faculty empower students by asking for their preferences exemplifies "cultural humility," defined as lifelong commitment to self-evaluation and self-critique, redressing the power imbalances in the trainee-supervisor dynamic, and developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships.⁴⁷

This study has limitations. Findings from participants in this single-institution study do not represent the thoughts or experience of all medical students. We did not address all possible microaggressions. We included students with a range of intersecting social identities but did not do separate analyses based on student demographics due to the risk of drawing conclusions with small numbers and violating student confidentiality. Finally, this study from the student perspective does not tell us how supervisors actually think about responding to microaggressions.

Looking forward, our team is investigating supervisors' perspectives on responding to microaggressions. It will also be important to study the role of the B-MIG in faculty development and further refine the guide.

Conclusions

An ideal bystander response incorporates students' preferences and microaggression context. Student

preferences are best revealed through a pre-brief discussion of microaggressions. The B-MIG is a visual representation of students' preferred microaggression response. Effective interventions promote educational safety and shift power dynamics in favor of the student target.

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