“Let’s Talk About What Just Happened”: a Single-Site Survey Study of a Microaggression Response Workshop for Internal Medicine Residents

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INTRODUCTION

Microaggressions, defined as verbal, behavioral, or environmental communications that convey hostility, invalidation, or insult based on an individual’s marginalized status in society, are ubiquitous in health care and medical training.1,2 Emerging data from medical trainees have shown an association between the frequency of mistreatment and feelings of burnout and suicidal thoughts.3 Microaggressions are difficult to respond to, especially for trainees who are learning to maintain therapeutic alliances, balance principles of medical ethics, and negotiate medical hierarchies. There are growing calls to incorporate practical training on responding to microaggressions into medical education.3–5 In this study, we describe a microaggression response toolkit (MRT) and workshop for residents, and their effects on perceived abilities to identify and respond to microaggressions.

METHOD

Based on literature and in consultation with a resident working group, we developed the MRT to describe strategies for responding to microaggressions as a target or witness (Fig. 1).2,4–6 We designed a fifty-minute workshop for internal medicine residents based on the MRT and informed by concurrent trainings at the associated medical school3 with the following goals: identify microaggressions using case scenarios, describe the impact of microaggressions on provider wellbeing and learning environments, and practice response strategies through role plays. Case scenarios and role play prompts were developed using published qualitative research and resident-reported microaggressions.

We performed electronic pre- and post-surveys to assess the utility of the workshop. Participants were asked to assess their comfort identifying microaggressions (1 = not at all comfortable, 5 = very comfortable); understanding of the potential impact of microaggressions (1 = do not understand, 5 = fully understand); and confidence in responding to microaggressions (1 = not at all confident, 5 = very confident). They were asked about the perceived importance of microaggression training and its value. They had the option to provide additional comments and make suggestions for improvement. Survey completion was voluntary and anonymous with no compensation.

RESULTS

The workshop was delivered during three sessions to 85 residents total (79% of approximately 107 eligible residents; 15 to 40 residents per session) of mixed post-graduate years (PGY1-PGY3) during March and April 2019, as part of a retreat and a noon conference series; participation was highly encouraged but not mandatory. It was facilitated by a senior resident (HF) with faculty mentor support (PC, JS, MAY). There were 55 responses to the pre-workshop (65% response rate) and 37 responses to the post-workshop surveys (44% response rate).

We calculated the percentage of respondents who reported a 4 or 5 on Likert scales described above. After the workshop, residents reported increased comfort with identifying microaggressions (29% pre-survey vs 89% post-survey selected “comfortable” or “very comfortable”), improved understanding of the potential impact of microaggressions (62% pre-survey vs 97% post-survey selected “understand” or “fully understand”), and increased confidence in responding to microaggressions (13% pre-survey vs 70% post-survey selected “confident” or “very confident”). On the pre-survey, 75% of residents agreed or strongly agreed that training on microaggressions should be part of the curriculum. On the post-survey, 97% of responding residents agreed or strongly agreed that the workshop was a worthwhile use of time. Residents frequently cited the MRT and practice scenarios as the best part of the workshop. For improvement, they suggested providing more time for discussion and incorporating more complex microaggression scenarios.
In this study, we found that participation in a brief, practical workshop on microaggressions using the MRT was associated with improvements in self-reported comfort in identifying microaggressions, understanding of their impacts, and confidence in responding to them. Limitations of this study include the small sample size, selection bias in participating residents, the low survey response rate with variable response rates by group size, single-site application, and the use of self-reported outcomes. Future work is needed to determine the durability of benefits and whether residents’ perceived comfort with addressing microaggressions translates into real-world experiences.

The MRT could be easily disseminated to other institutions, delivered at the different levels of medical education, and adapted for interprofessional providers. By increasing knowledge and self-efficacy around management of microaggressions, we may be better able to mitigate microaggressions’ noxious effects. This is especially important as we respond to a global pandemic and for reaffirming commitments to a culture of equity, inclusion, and trust.
Compliance with Ethical Standards:

Conflict of Interest: The authors have no conflicts of interest.

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