DIVERSITY, EQUITY & WELLNESS

Implicit bias and microaggressions in clinical practice

DEPARTMENT OF OTOLARYNGOLOGY - GRAND ROUNDS

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DR GINA TRINH, PGY4

DR DANIELLE MACNEIL & DR LORNE PARNES

Land Acknowledgement

Anishinaabek

Haudenosaunee

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Attawandaron

ACKNOWLEDGEMENTS

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- Dr. Danielle MacNeil for guiding this presentation and for being a strong female mentor
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OUTLINE

1. Racial and Gender Diversity
2. State of Diversity within Otolaryngology
3. Implicit Bias & Micro-Aggressions
4. Impact of micro-aggressions on health care providers
5. Learning how to address microaggressions

objectives

Understand	Understand the definition and implications of implicit bias and acknowledge ones own personal (unconscious) biases
Recognize	Recognize behaviours that are considered microaggressions and their impact on the receiver
Develop	Develop strategies to address microaggressions in real time

WHY DO WE NEED DIVERSITY?

- Social science experiments investigating the impact of group composition on problem solving consistently demonstrate the benefits of diversity

> **"Simply interacting with individuals who are different forces the entire group to prepare more comprehensively, anticipate alternative viewpoints, and expect that reaching consensus will take effort."**

Francis CL, Villwock JA. Diversity and Inclusion-Why Does It Matter. *Otolaryngol Clin North Am*. 2020;53(5):927-934.

DIVERSITY IN HEALTH CARE?

- Population of Canada and US are becoming increasingly diverse
  - Minority - majority population
- Minority and marginalized populations receive substandard care :
  - 2020 retrospective cohort study in the US [2007-2015] demonstrated African American and Hispanic patients incur lower average costs per visit than Caucasians;
  - Lower rates of outpatient otolaryngology care (more visits to ER)
  - Uninsured, low-income patients without higher education were significantly less likely to receive outpatient otolaryngology care
- In part because they are being treated by a homogenous group of health care providers that do not have insight/experience into many of these peoples' issues

Ruthberg JS, Khan HA, Knusel KD, Rabah NM, Otteson TD. Health Disparities in the Access and Cost of Health Care for Otolaryngologic Conditions. *Otolaryngol Head Neck Surg*. 2020;162(4):479-488.

GENDER DIVERSITY IN MEDICINE

- 8.9% of matriculated US medical students identified as LGBTQ+; 0.7% identified as TGNB.
- There are now more female medical school graduates and residents in Canada.
- Studies investigating differences in male and female physician care have shown consistent pattern of better patient outcomes when treated by a female physician:

Crit Care Med. Author manuscript; available in PMC 2020 Jan 1.
Published in final edited form as:
Crit Care Med. 2019 Jan; 47(1): e8–e13.
doi: 10.1097/CCM.0000000000003464

PMCID: PMC6298820
NIHMSID: NIHMS1505996
PMID: 30303843

"Female Physician Leadership During Cardiopulmonary Resuscitation Is Associated with Improved Patient Outcomes."

Angela Meier, M.D. Ph.D,[1] Jenny Yang, M.D.,[2] Jinyuan Liu,[4] Jeremy R. Beitler, J M.D., M.P.H.,[6] Xin M. Tu, Ph.D.,[4] Robert L. Owens, M.D.,[2] Radhika L. Sundararajan, M.D. Ph. D.,[7] Atul Malhotra, M.D.,[2] and Rebecca E. Sell, M.D.[2,3]

Research

Comparison of postoperative outcomes among patients treated by male and female surgeons: a population based matched cohort study

BMJ 2017 ; 359 doi: https://doi.org/10.1136/bmj.j4366 (Published 10 October 2017)

Comparative Study > JAMA Intern Med. 2017 Feb 1;177(2):206-213.
doi: 10.1001/jamainternmed.2016.7875.

Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians

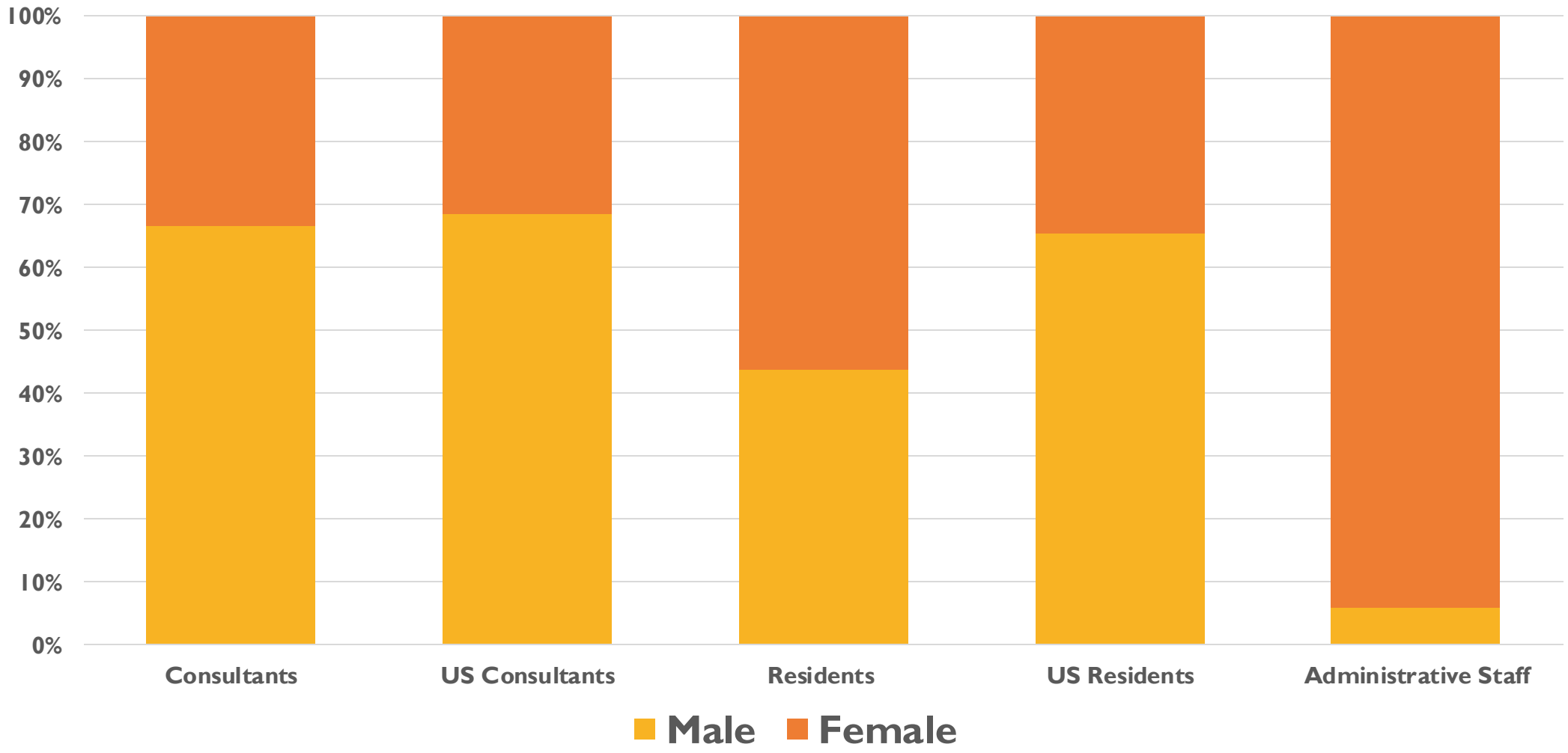
Yusuke Tsugawa [1], Anupam B Jena [2], Jose F Figueroa [1], E John Orav [3], Daniel M Blumenthal [4], Ashish K Jha [5]

Affiliations + expand

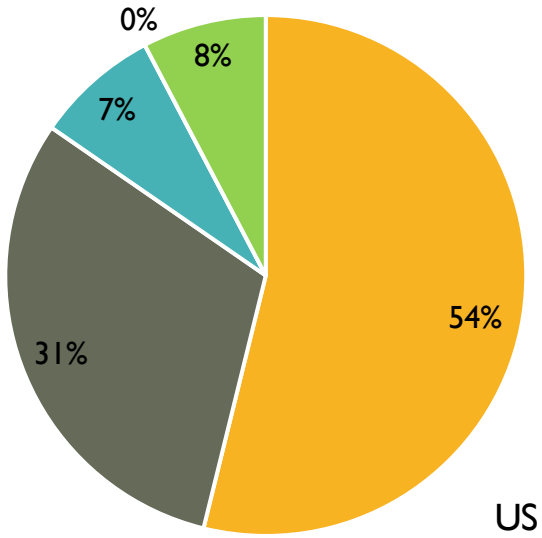
PMID: 27992617 PMCID: PMC5558155 DOI: 10.1001/jamainternmed.2016.7875

Oscar E. Dimant, Tiffany E. Cook, Richard E. Greene, and Asa E. Radix. **Experiences of Transgender and Gender Nonbinary Medical Students and Physicians.** Transgender Health.Dec 2019.209-216.

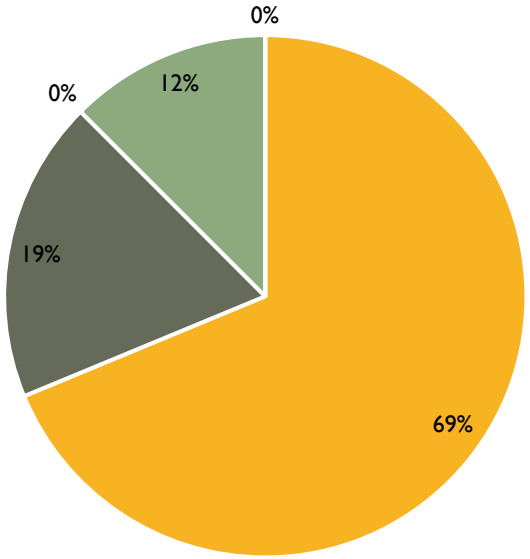
SNAPSHOT OF WESTERN OTOHNS DIVERSITY



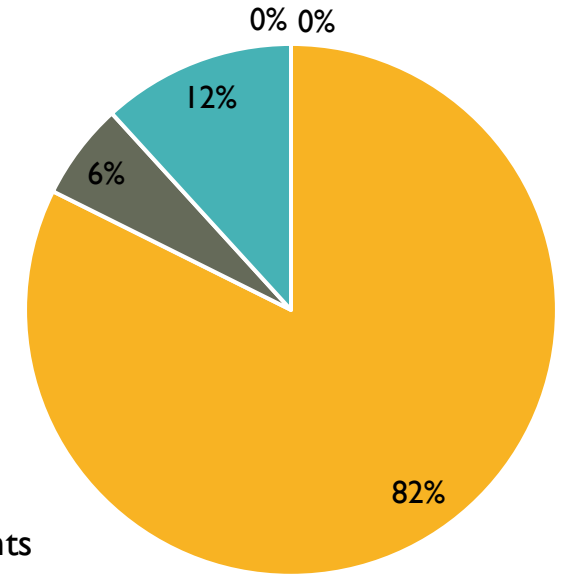
UWO consultants



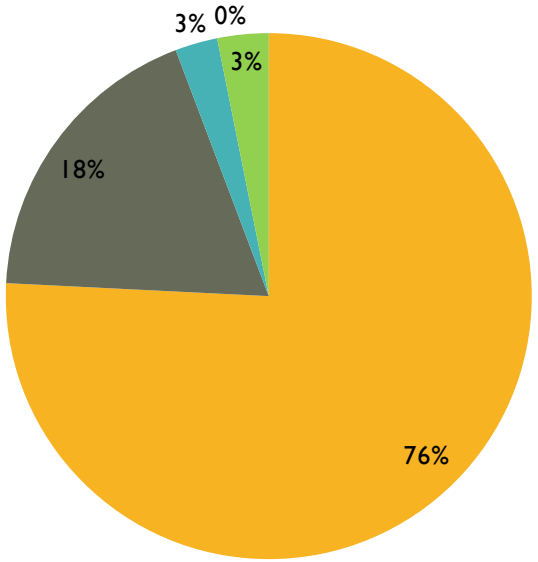
UWO residents



Administrative staff



US Consultants



US Residents

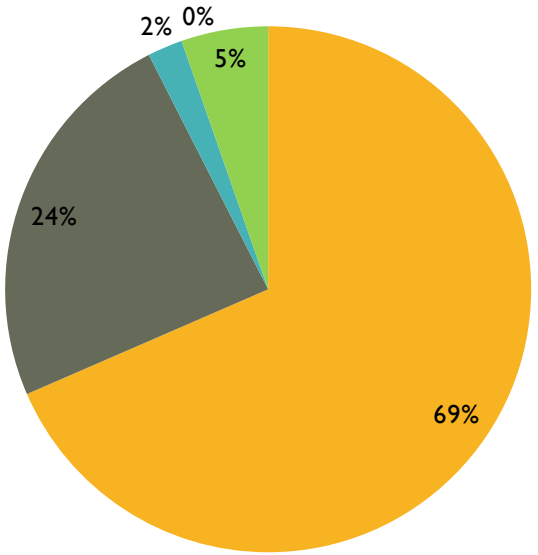


Chart Area

White Asian African Middle Eastern Hispanic

PLOS ONE

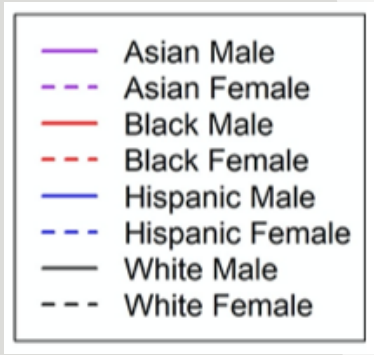
RESEARCH ARTICLE

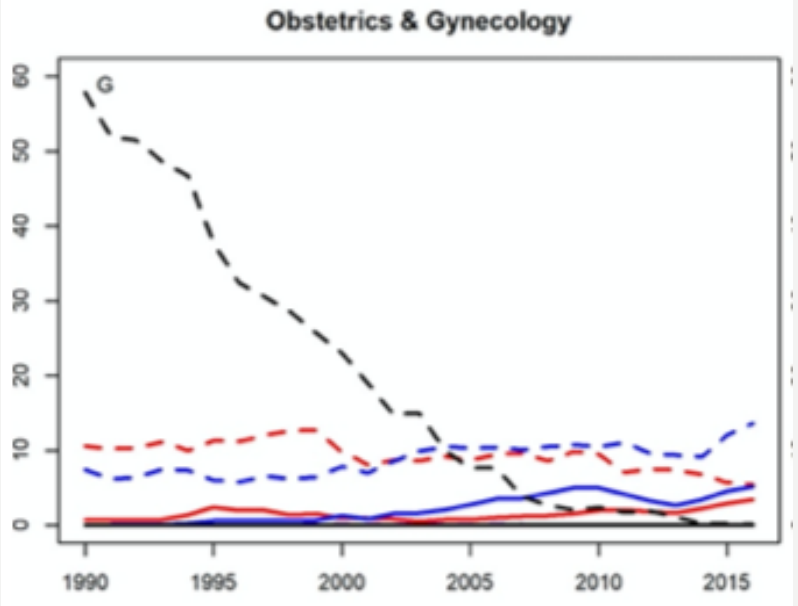
Declining racial and ethnic representation in clinical academic medicine: A longitudinal study of 16 US medical specialties

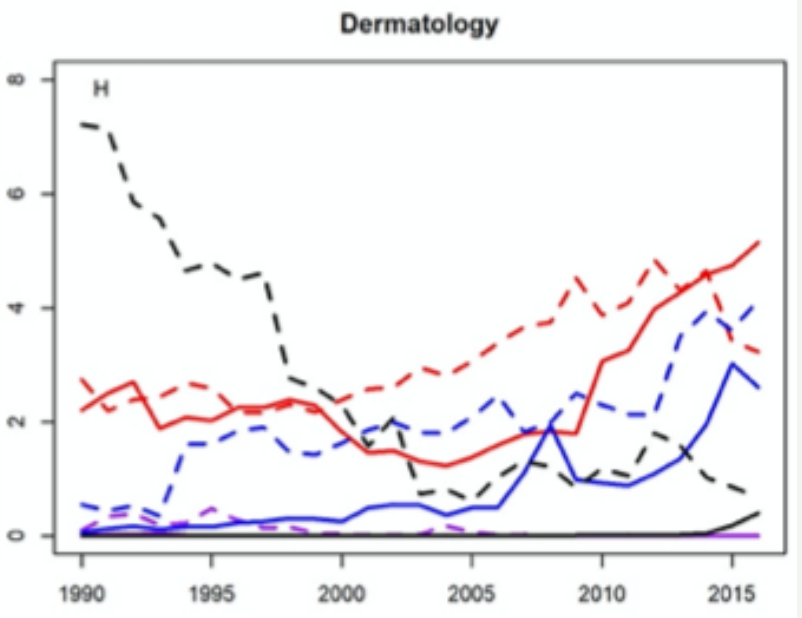
Lanair Amaad Lett[1], **Whitney U. Orji**[1], **Ronnie Sebro**[1,2,3,4]*

1 Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania, United States of America, **2** Department of Radiology, University of Pennsylvania, Philadelphia, Pennsylvania, United States of America, **3** Department of Biostatistics, Epidemiology, and Informatics, University of Pennsylvania, Philadelphia, Pennsylvania, United States of America, **4** Department of Genetics, University of Pennsylvania, Philadelphia, Pennsylvania, United States of America

METHODS

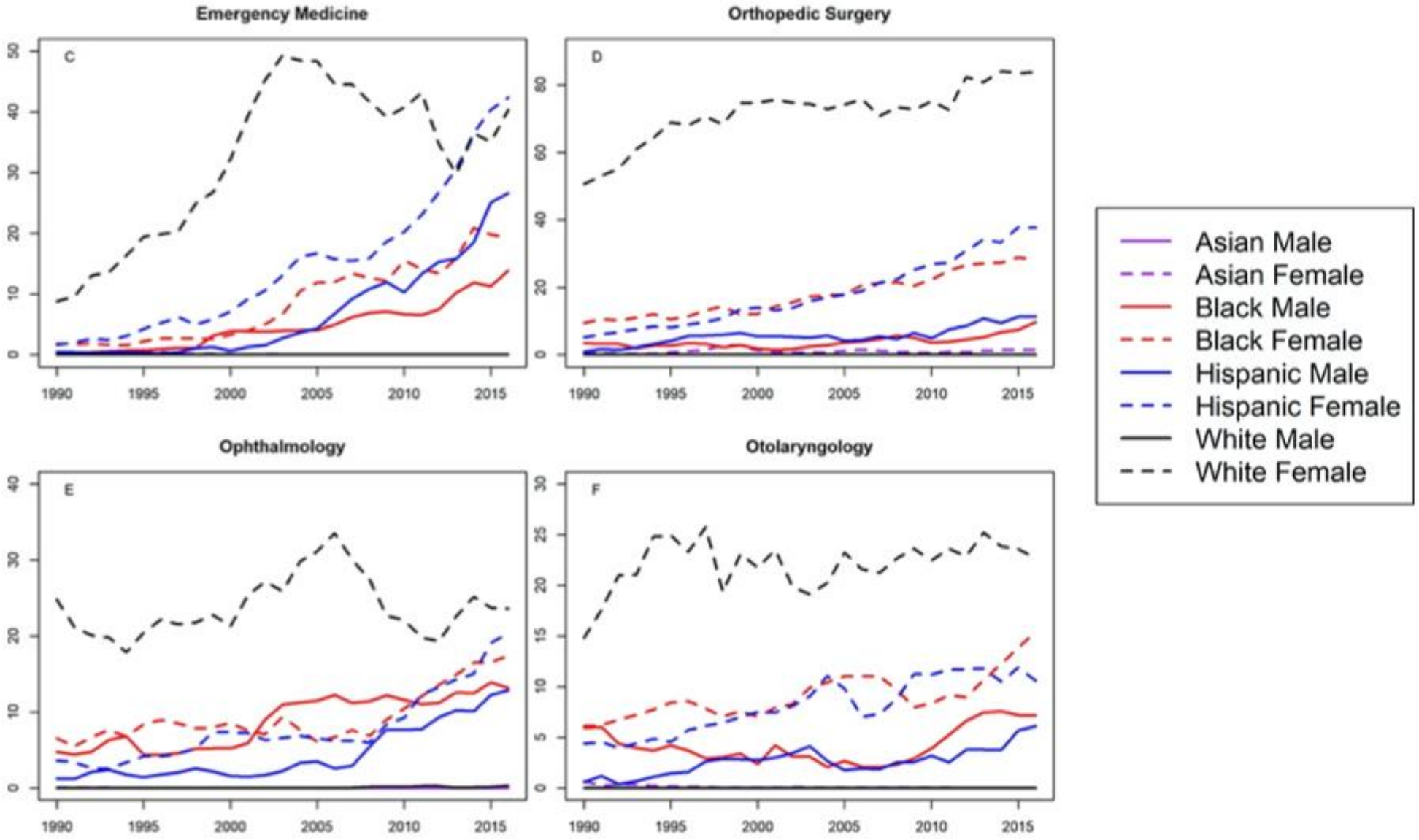




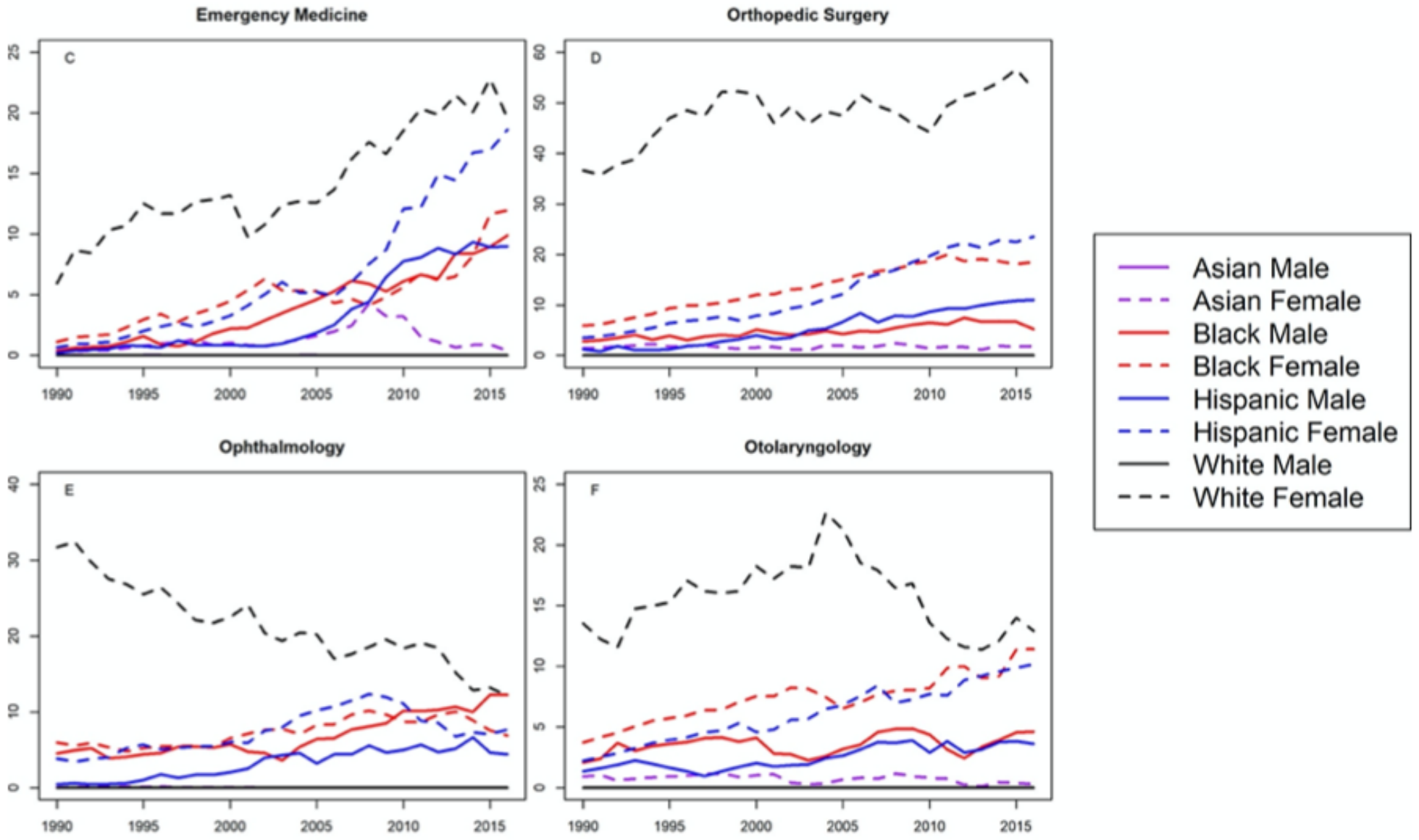


- S score – measure of the deviation of a sample proportion from a known population proportion, **where the sample is the academic medical faculty, and the population is the census**.
- Higher S-scores = more severe underrepresentation.
- Under-representation = S-score greater than 1.602 (p-value of less than 0.025)
- Over-representation = S-score less than 0.0109 (p-value greater than 0.975)

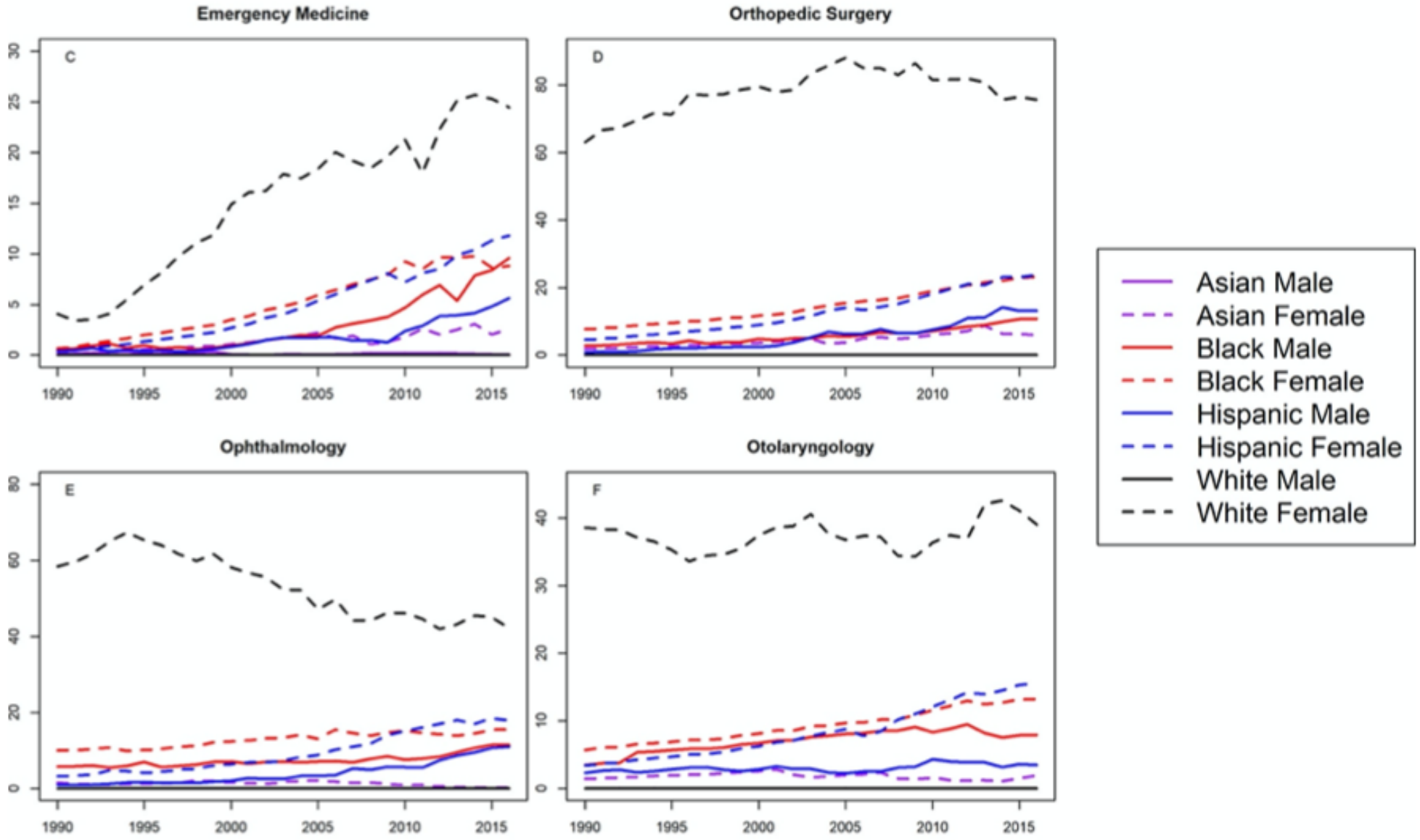
S-SCORE FOR ASSISTANT PROFESSORS BY SEX, RACE/ETHNICITY AND DEPARTMENT

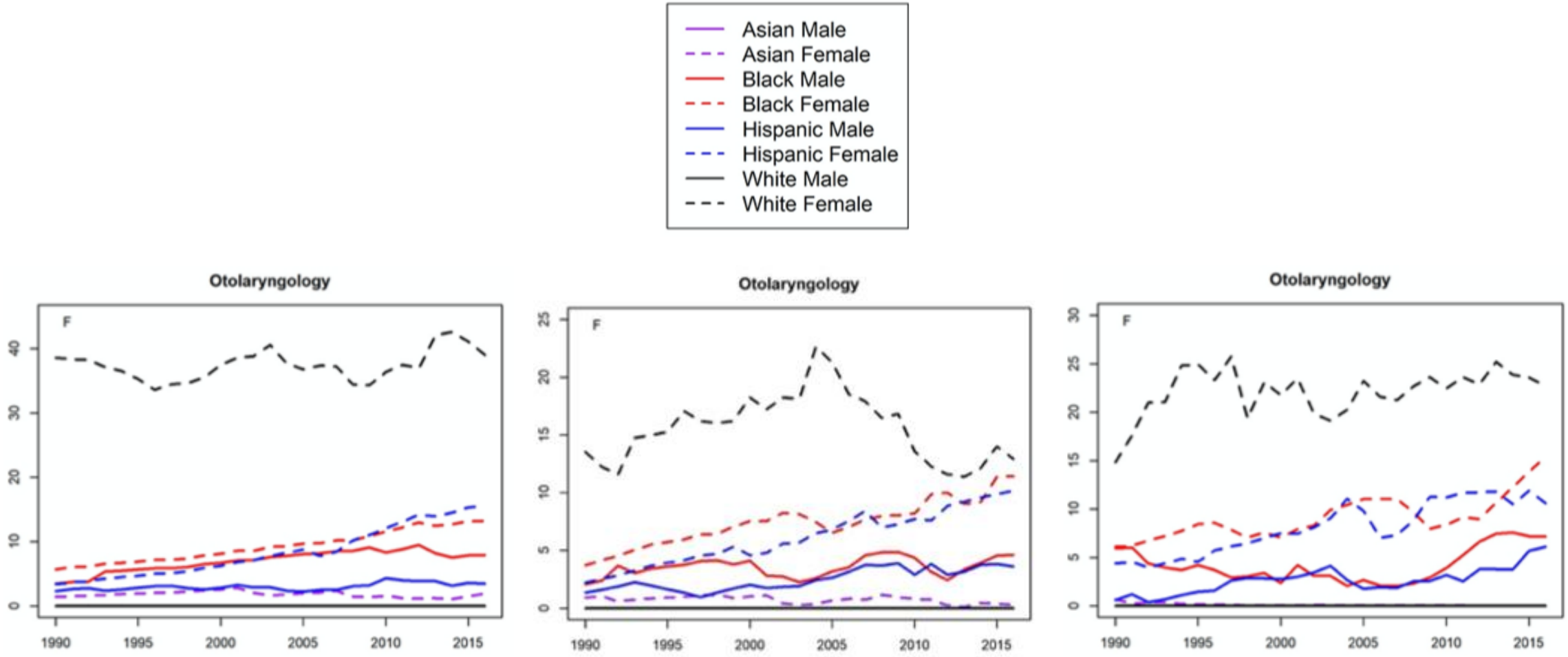


S-SCORE FOR ASSOCIATE PROFESSORS BY SEX, RACE/ETHNICITY AND DEPARTMENT



S-SCORE FOR FULL PROFESSORS BY SEX, RACE/ETHNICITY AND DEPARTMENT





ASSISTANT

ASSOCIATE

FULL PROFESSOR

Voices | Opinion

Female Surgeons Are Still Treated as Second-Class Citizens

The profession is rife with sexual harassment, bullying and discrimination—and that needs to change

By Chethan Sathya on January 14, 2020

EVIDENCE OF DISPARITY

- Wage disparity
- Unfair resource allocations
- Low representation in leadership, academic medicine
- Positions held by females are often are associated with “less power”
- Women investigators are less likely to be awarded research funding within the NIH

- 2/17 Canadian Dean of Medicines are female
- 8/26 OMA Board of Directors are female
- 6/26 CMA Board of Directors are female

https://cmajnews.com/2018/03/26/rise-of-women-in-medicine-not-matched-by-leadership-roles-cmaj-109-5567/

IF WE LIVE IN A MODERN, PROGRESSIVE SOCIETY, WHY IS THIS STILL HAPPENING?

IMPLICIT BIAS

- We all have them
- Evolutionary advantage?
- Cumulation of the way we were brought up, our life experiences, interactions
- Occur without our awareness - UNCONCIOUS
- Often biases are contrary to our personal values (or explicit bias)
- While invisible to the person, they are often very recognizable to the other party

MICRO-AGGRESSIONS

: Subtle verbal or nonverbal behaviours arise from unconscious biases, covert prejudice or hostility.

- Micro – refers not to the insignificance of these exchanges but rather their being "common place, daily exchanges"
- In contrast to aggressions, microaggressions are fleeting everyday occurrences that may be unconscious, unintentional and unnoticed by the aggressor.

- Macroaggressions – occur on institutional or systemic levels. Manifests as biased or discriminatory policies, governance, and other practices that disproportionately benefit one group other another.
  - Slave monitor
  - No lactation room at Victoria Hospital

INTENT & IMPACT

Intent is the meaning meant by the actor

- Often not malicious
- Uninformed
- Unaware

Impact is the effect of the behaviour on the recipient

- Degrading
- Derogatory

MY EXAMPLE

- During a rotation in northern Ontario, my white older, female supervisor expressed to me that she was concerned that the "indigenous people wouldn't connect with me, because I don't smile much"
- This comment came after our venture to a remote nursing station when she received positive feedback about me.
- At the time, I didn't really understand the meaning, nor the implications. Honestly, I was confused why my not *always* smiling would have any bearing on my ability to provide health care.

MORE RECENTLY…

- After doing the surgical pause for an operative patient, I examined the patient's large ulcerated skin cancer near the patient's eye without gloves. The OR nurse started to say "I can't believe you would touch that without gloves… you could get diseases … you need to wear gloves."
- Moments later, the male surgeon walks in, proceeds to examine the cancer after me, without gloves.
- No comment

OTHER CURRENT EXAMPLES

- Orders written by female medical students are routinely questioned by nurses and re-confirmed by the resident, whereas this does not occur with male medical students

- While on CCTC and managing an acutely unwell patient with high ICP, a female resident verbally asked for mannitol, and the nurse argued and refused. Moments later, her male colleague (same level) entered, and said the same thing, there was no resistance.

EXAMPLES OF RACIAL MICROAGGRESSIONS

Theme	Microaggression	Message
Denial of racism	"All lives matter"	All lives do matter; but in this context it's black lives that seem to matter less when they're not being treated with respect.
Colour blindness	"When I look at you, I don't see colour"	Dismiss, ignore and make invisible the pain and suffering of people of color.
Racial	Hey "Eduardo" – actually named Edwin	You must have an ethic name because of the way you look

OTHER EXAMPLES

Theme	Microaggression	Message
Minority	"So where are you *really* from?"	You don't look Canadian
Gender	Female trainees asked to "smile more," "soften their tone," or to "not sound so authoritative" because others perceive them as being "angry" or "intimidating" and unsafe to approach	Your appearance defines what people think of you
Gender	"Does this patient really need to be admitted" – when female surgeon admits patient	You aren't capable of making decisions
Sexual	"So who wears the pants in the relationship?"	Implies a normal relationship includes a man and woman

IMPACT OF MICROAGGRESSIONS

SHORT TERM

- Anxiety
- Stress
- Depression
- Sleep difficulties
- Helplessness
- Loss of motivation/drive,
- Diminished cognition
- Drug misuse

LONG TERM

- Erosion of self confidence
- Personal/family life disruption
- Burnout
- Drug dependence
- Suicidality

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training

October 31, 2019
N Engl J Med 2019; 381:1741-1752
DOI: 10.1056/NEJMsa1903759

- Residents completed a survey administered after the 2018 ABSITE (in training exam) for all ACGME General Surgery programs in the US
- Mistreatment exposures: gender, racial discrimination, verbal or emotional abuse, physical abuse, sexual harassment, pregnancy/childcare discrimination
- Frequency of exposure: no exposure, few times/yr, few times or more/month
- Resident and program characteristics, how often there was violation of 80h work week.
- Outcomes: symptoms of burnout and suicidal thoughts
- 7409/7464 (99.3%) responses

Table 3. Sources of Discrimination, Harassment, and Abuse Reported in a Survey of U.S. Surgical Residents.*

Source of Mistreatment	Gender Discrimination			Racial Discrimination			Verbal or Emotional Abuse		
	number (percent)								
	All	Men	Women	All	Men	Women	All	Men	Women
	2366	442	1912	1227	671	547	2238	1257	968
Patient or patient's family	1032 (43.6)	87 (19.7)	940 (49.2)	581 (47.4)	257 (38.3)	320 (58.5)	181 (8.1)	108 (8.6)	73 (7.5)
Attendings	468 (19.8)	126 (28.5)	337 (17.6)	213 (17.4)	151 (22.5)	61 (11.2)	1173 (52.4)	652 (51.9)	512 (52.9)
Administration	16 (0.7)	10 (2.3)	6 (0.3)	20 (1.6)	13 (1.9)	7 (1.3)	25 (1.1)	14 (1.1)	11 (1.1)
Co-residents	179 (7.6)	56 (12.7)	121 (6.3)	101 (8.2)	59 (8.8)	41 (7.5)	451 (20.2)	232 (18.5)	217 (22.4)
Nurses or staff	503 (21.3)	50 (11.3)	452 (23.6)	131 (10.7)	73 (10.9)	56 (10.2)	177 (7.9)	102 (8.1)	73 (7.5)
Source not identified	169 (7.1)	113 (25.6)	56 (2.9)	181 (14.8)	118 (17.6)	62 (11.3)	231 (10.3)	149 (11.9)	82 (8.5)

- More than 50% of residents reported mistreatment
- All mistreatment types reported higher frequency experienced by females
  - 30% reported frequency of few times or more/month
- Median prevalence within each program:
  - Gender discrimination 67% among women
  - Racial discrimination 16%
  - Pregnancy or childcare 12%
  - Verbal or physical abuse 30%
  - Sexual harassment 17% among women

Factors associated with burnout

- Early PGY year (OR 1.21 95%CI 1.06-1.38)
- Increasing frequency of mistreatment (stepwise OR 2.94 95%CI 2.58-3.36)
- Increasing frequency of duty hour violations (stepwise OR 2.91 95%CI 2.52-3.35)

Factors associated with suicidality

- Not in relationship or divorced/widowed (OR 1.31 95%CI 1.03-1.66)
- Increasing frequency of mistreatment (stepwise OR 3.07 95%CI 2.25-4.19)
- Increasing frequency of duty hour violations (stepwise OR 2.12 95%CI 1.56-2.88)

Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis

Acad Med. 2014;89:817–827.

Naif Fnais, MS, Charlene Soobiah, Maggie Hong Chen, PhD, MSc, Erin Lillie, MSc, Laure Perrier, MLIS, Mariam Tashkhandi, MD, Sharon E. Straus, MD, MSc, Muhammad Mamdani, PharmD, MA, MPH, Mohammed Al-Omran, MD, MSc, and Andrea C. Tricco, PhD, MSc

- Meta-analysis identified 59 studies; from the US, Canada, Pakistan, UK, Isreal, Japan
- Looked at types of harassment: verbal, physical, sexual, academic, gender or race
- The MOST COMMON source of harassment: physicians (34%), patients (22%), nurses (15%), fellow learners/residents (15%), others (3%)
- 4 studies found residents in surgical training programs reported high incidence of harassment and discrimination compared to other programs

- Residents cited **gender** discrimination as the most form of abuse (n=3 studies, 1315 residents), followed by verbal, least common racial

Table 2

Comparison of the Prevalence of Harassment and Discrimination Among Medical Students and Residents, According to Studies Identified in a 2011 Systematic Review of the Literature

	No. studies		Sample size		Mean		95% CI	
Type of harassment	S	R	S	R	S	R	S	R
% Harassment	30	19	26,579	11,193	59.6	63.4	49.2–68.0	53.6–73.2
% Verbal abuse	16	12	18,865	9,867	68.8	58.2	56.6–81.0	45.5–70.9
% Gender discrimination	10	3	4,922	1,315	49.8	66.6	34.6–65.0	58.7–74.5
% Academic	10	4	3,062	2,257	39.5	27.7	26.8–52.2	6.0–49.4
% Sexual	25	10	22,316	7,077	33.3	36.2	27.2–39.4	19.8–52.6
% Racial discrimination	7	3	16,121	3,261	23.7	26.3	13.6–33.9	24.2–28.3
% Physical	15	10	18,790	6,760	9	28.9	7.0–11.1	15.9–41.8

Abbreviations: CI indicates confidence interval; S, medical students; R, residents.

POST HOC ANALYSIS

- 37 pool north American studies (US and Canada): pooled prevalence for harassment = 64%
- No difference between years of training, primary language of training (English vs non English)
- When classified by the World Bank's classification of economic countries, there was a higher pooled prevalence of harassment in *higher income* countries:
  - High income countries (50 studies, 24,197 trainees, pp 64%, 95% CI 57-70%)
  - lower income countries (6 studies, 2,877 trainees, pp 49%, 95% CI 94-73%)

INTERSECTION OF GENDER & RACE

Intersectionality:

"Because of their intersectional identity as women AND of colour, [discourses that are shaped to respond to feminism or racism fail to represent their experience]"

- Kimberle Crenshaw. Stanford Law Review: Mapping the Margins: Intersectionality, Identity Politics and Violence Against Women. 1991.

"Intersectional experience is **greater than the sum of racism and sexism"**

Common Types of Gender-Based Microaggressions in Medicine

Vyjeyanthi S. Periyakoil, MD, Linda Chaudron, MD, MS, Emorcia V. Hill, PhD,
Vincent Pellegrini, MD, Eric Neri, MS, and Helena C. Kraemer, PhD

- Women in medicine provided clinical examples of real life microaggressions. 34 real life examples were translated into video vignettes performed by actors, paired with a control scenario without the microaggression
- 68 videos were assessed by 7 senior faculty (3 men for 4 women) for final use
- Four study schools were chosen for geographic location and private/public medical schools: Stanford, University of Rochester, Harvard Medical School and Medical University of Southern Carolina)
- Faculty from these schools were invited to participate
- Data collected between 2016-2018 and anonymous

Based on your own knowledge and experience and that of your colleagues and students at your institution and settings, is this scenario something that:

(a) Has never happened nor is likely to ever happen
(b) Happens rarely or will happen rarely
(c) Happens or will happen to a lot of people
(d) Affects every person sometime in their career

Table 1

Demographic Characteristics of 124 Participants in a Study of Common Types of Gender-Based Microaggressions in Medicine, 2016–2018

Characteristic	No. (%)
Gender	
Female	79 (63.7)
Male	45 (36.3)
Age in years	
30–39	22 (17.7)
40–49	35 (28.2)
50–59	35 (28.2)
60–69	26 (21.0)
70–79	4 (3.2)
80 and older	2 (1.6)
Academic rank	
Full professor	41 (33.1)
Associate professor	46 (37.1)
Assistant professor	30 (24.2)
Instructor	7 (5.6)
Race/ethnicity	
Caucasian	100 (80.7)
Black or African American	5 (4.0)
Hispanic American	6 (4.8)
Asian American	12 (9.7)
Mixed	1 (0.8)

VIDEO VIGNETTES

RESULTS

Most common themes:

1. Encountering sexism
2. Encountering pregnancy or child care related bias
3. Having abilities underestimated
4. Encountering inappropriate (sexual) comments
5. Being relegated to mundane tasks
6. Feeling excluded/marginalized

- Women reported much higher frequency of the microaggressions depicted in 33/34 microaggression videos than men
- In start contrast, men reported microaggressions to be *uncommon*
- No differences were noted in the control videos
- No effect of demographic factors including age, academic rank and race

In his essay on microaggressions and epistemic injustice, M. Tschaepe wrote, "microaggressions undermine the credibility of knowers, and their capacity for becoming knowers. Marginalization and depersonalization from microaggressions places persons who are targets of microaggressions in a position in which their autonomy is called into question and diminished."[3]

The experience of being devalued diminishes an individual's ability to fully participate in complex cognitive tasks. Repetitive mistreatment during training leads to negative emotional and physical repercussions, decreased work performance, and ethical distress.

Microaggressions committed against people early in their journey of professional identity formation has the potential to have a larger negative impact than when it occurs later in a physician's career. "It is important to emphasize that microaggressions are not about having hurt feelings. Rather, it is about the negative effect that being repeatedly insulted, invalidated, alienated, and dismissed have at both a micro [biological] and macro [social] level."

Montenegro R. Microaggressions during medical training (response). *JAMA.* 2016;316(10):1114.

ATTITUDES TOWARDS MICROAGGRESSIONS

- Historical teaching was to “turn a blind eye” or “take the high road”
- Not engage with inappropriate behaviours

Doing nothing is complicit to systemic racism; by staying silent, we are allowing the maintenance of racist and sexist behaviours

EXAMPLES IN MAINSTREAM MEDIA

WHAT CAN WE DO RIGHT NOW

- Acknowledge that they happen and for some people, on a daily occurrence
- Develop a framework to address microaggressions in a respectful and productive way
- Strengthen multi-disciplinary teamwork and identify strategies to promote healthy work environment
  - E.g. resident retreat
  - Rounds/JC on these subjects, WIO, wellness, resources burnout

FRAMEWORK TO ADDRESS MICROAGGRESSIONS

- Start the conversation
  - Observe, think, feel, desire
  - "I noticed that you interrupted me when I was talking to the patient [microaggression], which made me think that you didn't believe what I had to say was important [implication]. I am frustrated [emotion] by this and hope that we can listen to each other more moving forward [desired outcome]."

- Action
  - Ask clarifying questions, come from curiosity not judgement.
  - Tell what you observe as problematic in a factual manner

Addressing the Elephant in the Room: Microaggressions in Medicine Melanie F. Molina, MD;* Adaira I. Landry, MD, MEd; Anita N. Chary, MD, PhD; Sherri-Ann M. Burnett-Bowie, MD, MPH 2020

Dear anti-racist allies: Here's how to respond to microaggressions

By Kristen Rogers, CNN

Updated 4:57 AM ET, Sat June 6, 2020

- Make the invisible, visible
- Educate the person – shifting the focus from the **intent to the impact**

"That wasn't my intention, why are you so sensitive?"

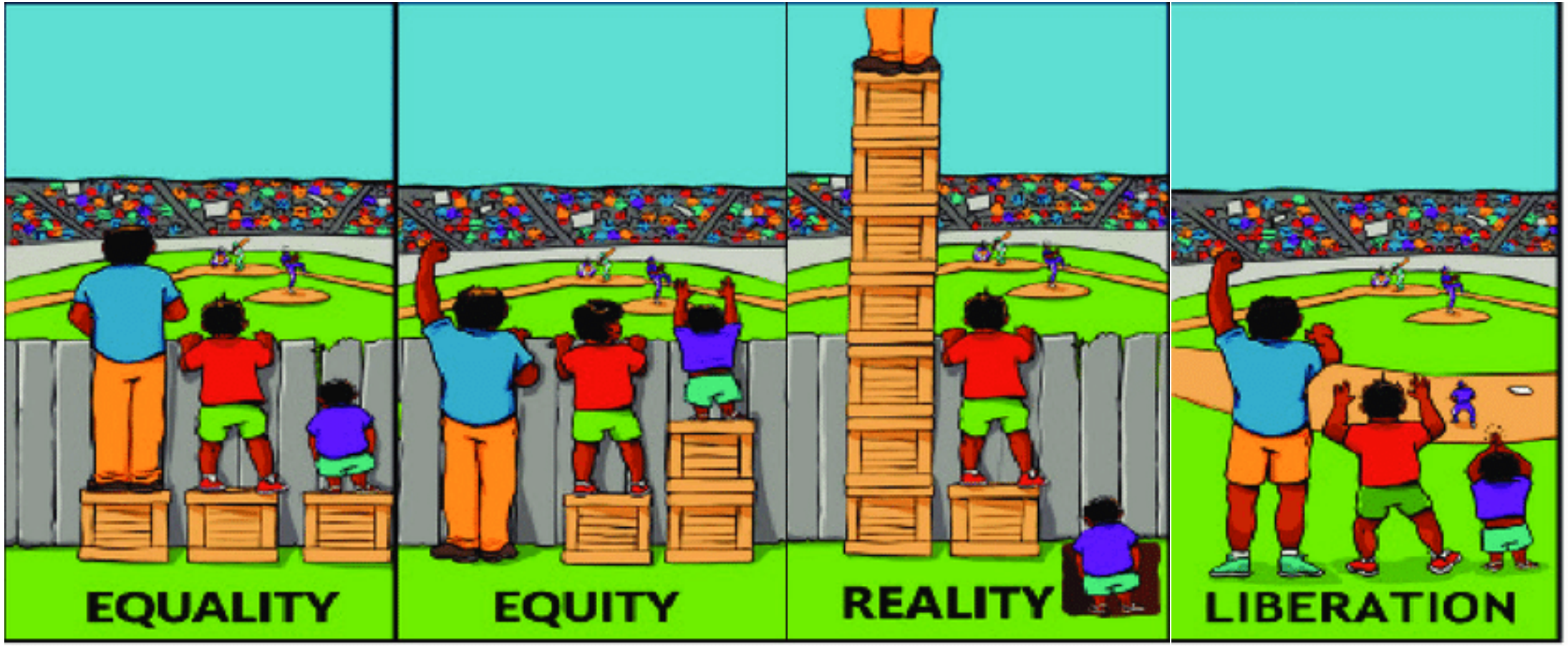
"I was just joking"

- Ask yourself: will further conversation be beneficial AND productive? Am I able to respond non-emotionally?
  - Reiterate that you are not blaming the person, only expressing how the comment made you feel
  - Explain that these instances occur daily and others have made similar remarks
  - Be open to their input and feelings

SYSTEMIC CHANGES

- Change institutional norms
  - Group leaders
- Create a culture in which people feel responsible for change
  - Mandatory diversity training modules/programs are unsuccessful because they challenge a person's autonomy
  - Mentoring or sponsorship programs (support autonomy and engagement)
- Implement behavioral guidelines and plans
  - Diversity statements
  - Specify exact plans and indicators for success: ex. Hiring committee should have at least 30% content of minority or female for 5 yrs. Outcome measure: minority new hires.
- Organizational accountability
  - Ex. Liberal government has achieved gender parity x2

Working toward gender diversity and inclusion in medicine: myths and solutions. Kang, Sonia K et al. The Lancet, Volume 393, Issue 10171, 579 - 586


EQUALITY
EQUITY
REALITY
LIBERATION

SUPPLEMENTAL SLIDES

MERITOCRACY

"a pretense, constructed to rationalize an unjust distribution of advantage."

- : that we should all be judged on our accomplishments; achieving upward societal movement through one's own merit

- Negates the structural barriers that exist for people of minority
- Promoting "colour blind" philosophy that anyone, regardless of race or status, can succeed if they work hard enough
- Accepted by young, upper class, white, rejected by older, working class, people of colour

“WHITE FRAGILITY”

“I’m color-blind”

”we treat everyone the same”

“I don’t care if you are …”

”I have friends of colour”

- The response of white people when racism is brought up
- “disbelieving defensiveness that white people exhibit when their ideas about race and racism are challenged.”
- Implication of complicity with white supremacy