Doi: 10.32481/djph.2022.10.013

Racism in Medicine:

Targeting Microaggressions in Delaware Healthcare (TMDH)

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Introduction

According to Oxford Languages, racism is defined as "prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership in a particular racial or ethnic group, typically one that is a minority or marginalized."[1] Due to racism in healthcare, people of color (POC) are experiencing higher rates of adverse health outcomes, including death.[2] Racism and discrimination can affect generations of people, some of whom are physicians, nurses, and health professionals.

Health Outcomes

The disparities in health outcomes between race and ethnicity are well documented and have become more apparent throughout the COVID pandemic. POC have disproportionately higher rates of mortality and disease in comparison to their White counterparts.[3–5] Hispanic patients, regardless of native-language, had a significantly higher mortality rate and reduced access to healthcare compared to White patients.[5] Among children (<18 years), Latino patients had the highest rates of hospitalization compared to White patients. American Indian or Alaska Native patients had the highest rates among adults aged 18 to 49 years. American Indian or Alaska Native, Black, and Latino patients, aged 65 years and older, had higher rates than White patients. Although hospitalization rates are positively correlated with age across all racial and ethnic groups, POC are more likely to be hospitalized, receive ICU care, or die with COVID-19–associated illness compared with White patients.[3]

Studies also show that patients of color report higher rates of delayed care and diagnoses in various specialties.[6–8] One study showed higher rates of appendicitis perforation and delayed diagnosis among non-Hispanic Blacks (NHB) when compared to non-Hispanic Whites (NHW).[9] Additionally, NHB children had the lowest rates of diagnostic imaging and a lower likelihood of definitive imaging when compared to NHW children. These findings suggest that patients with appendicitis symptoms may be treated differently based on race and ethnicity.

Microaggressions

A microaggression is "a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)."[10] Microaggressions are classified into three subgroups: microassaults, microinsults, and microinvalidations.[11] Microassaults are often conscious biases or discriminatory verbal abuse or behaviors. Examples of microassaults include calling an Asian patient "oriental" or a POC "colored." Microinsults are generally unintentional remarks that are insensitive and derogatory to a person's racial identity or background. Saying "you speak English well" to a Hispanic physician or nurse or assuming that they do not speak English entirely are

examples of microinsults. Microinvalidations are behaviors and statements that are meant to invalidate one's feelings, thoughts, and experiences.[11] Telling a POC healthcare professional that they only got to their position as a "diversity hire" is an example of microinvalidation.

Research indicates that microaggressions may lead to a slew of adverse psychological effects such as depression, stress, anxiety, and suicidal thoughts.[12–15] Additionally, there has been a correlation between microaggressions and somatic symptoms. Some conditions include high blood pressure, headaches & migraines, chronic infections, and excessive alcohol use.[16]

Implications

A 2021 study found that gender and whether or not an individual is under-represented in medicine (URM), influences their experiences with racism and microaggressions.[17] A person is URM if they are Black/African American, Native American, Mexican American, and/or Mainland Puerto Rican. Female first-year medical and dental students showed significantly higher rates of witnessing and personally experiencing microaggressions than male students.[17] Additionally, URM students reported significantly higher rates of experiencing microaggressions compared to non-URM students.

This phenomenon can also be seen in physicians of color. Seventy-one physicians of color completed a Racial and Ethnic Microaggressions Scale, Professional Quality of Life Scale, and a demographics questionnaire.[18] Of the 71 participants, 23.3% (n=17) reported that a patient refused their care specifically because of their race or ethnicity.[18] Participants who reported English as their second language reported significantly more instances of racism than their native-English peers. Furthermore, the occurrence of microaggressions was positively correlated with secondary traumatic stress and racism from patients and peers.[18]

There is a gap in research about the underlying cause of health outcomes across all racial and ethnic groups. One possible explanation is that POC are reluctant to participate in studies due to the history of unethical medical practices, such as the Tuskegee experiments.[19] Another may be due to fear of discrimination by medical professionals. Microaggressions, whether unconscious or conscious, can negatively affect the physician-patient experience. By preventing and addressing such occurrences, there is a potential to improve long-term outcomes.

National Programming

Although there are initiatives to combat discrimination and promote diversity, there is a lack of movement in addressing microaggressions nationally.[20] The only resource of note was from the National Institutes of Health (NIH). The NIH cites the *Diversity in the Classroom* booklet by The University of California, Los Angeles's (UCLA) office of Diversity & Faculty Development as a tool to prevent, identify, and counter microaggressions.[21] *Diversity in the Classroom* is prefaced by "UCLA's Principles of Community" which compromise of "we" statements about how UCLA plans to foster a welcoming and inclusive campus environment.[21]

Current Programming in Delaware

In 2015, the Delaware Division of Public Health and the University of Delaware's School of Public Policy & Administration created the Health Equity Guide for Public Health Practitioners and Partners which outlines techniques and tools to help all workplaces and institutions in

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adopting health-promoting policies.[22] The guide also addresses racial inequalities through social determinants of health and population-based strategies of Healthy People 2020.

The Division of Public Health is in the process of implementing The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards).[2] CLAS is a strategy to improve health outcomes by tailoring services to an individual's culture and language preference. The CLAS standards also provide an outline for health care organizations to introduce culturally and linguistically appropriate services.

Social Cognitive Theory

Social Cognitive Theory (SCT), formerly known as Social Learning Theory (SLT), was developed by Albert Bandura.[23] SCT accounts for the interaction between people (personal factors), their behavior, and their environments. There are six constructs in SCT: reciprocal determinism, behavioral capability, observational learning, reinforcements, expectations, and self-efficacy.

Reciprocal determinism is the principal construct of SCT. It means an individual can be both an agent for change and a responder to change. Behavioral Capability refers to a person's ability to perform a behavior through the use of resources, knowledge, and/or skills. In other words, an individual must understand what the desired behavior is, and how to perform it. Observational Learning, or modeling, reasons that people can witness and observe the desired behavior conducted by others, and then imitate the actions. Reinforcements are "the [positive or negative] internal or external responses to a person's behavior that affect the likelihood of continuing or discontinuing the behavior."[24] Expectations refer to the anticipated consequences of an individual's behavior and generally stem from past experiences. Self-efficacy is the belief or confidence an individual has to successfully perform a behavior despite barriers or obstacles.

SCT in Practice

Much like SCT, reciprocal determinism is at the core of Targeting Microaggressions in Delaware Healthcare (TMDH). The program is designed so that individuals can recognize microaggressions, prevent them from occurring, or counter them upon witnessing an occurrence. This enables an individual to be both an agent and responder for change. Behavioral capability will be managed through lecture-style workshops and informational websites & brochures. This will provide the resources and knowledge needed in order to address microaggressions. Observational learning will be targeted through role-playing workshops and website videos. TMDH focuses on both intrinsic and extrinsic reinforcements. The intent is that an individual chooses to engage in anti-microaggression behavior in order to relieve personal emotional distress while also facilitating a positive social environment. In regards to expectations, participants may have a negative perspective due to their previous experience with microaggressions. TMDH intends to alleviate negative feelings by creating a safe place to learn and communicate in its workshops, which will in turn make participants more amenable to behavioral change. Self-efficacy is targeted much like the constructs of behavioral capability and observational learning. By teaching how to acknowledge and respond to microaggressions the aim is that participant self-efficacy will increase.

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Program Description

TMDH is a two-pronged program that will address microaggressions through didactic workshops at various health institutions and public advertisements placed throughout Delaware (see Appendix A). The first prong is targeted towards participating health institutions and Health Care Providers (HCPs) in which they will participate in biweekly workshops. Prior to workshops, participants will be emailed a survey regarding their knowledge of microaggressions (see Appendix B). One workshop will be lecture-based teaching the participants what microaggressions are, what they look like in a healthcare setting, and how to address them. The second workshop will be conducted through role-playing where participants will reenact real-life scenarios experiences submitted by the participants or research team. After workshops are concluded, a post-survey will be sent to participants about their experience in the workshops and whether their knowledge has improved.

The second prong is targeted towards the general public in Delaware. An informational website will be created that encompasses definitions, explanations, and short role-playing videos about microaggressions. The website will also contain optional pre and post-survey that the public can partake in. Advertisements about the website will be posted on buses and billboards throughout the state. Outcomes will be measured by metrics such as website clicks and survey responses. All participants, in either prong, are welcome regardless of race, sex, gender, sexual orientation, and socioeconomic status. Additionally, informational brochures will be provided to all participating institutions to display in patient waiting rooms (see Appendix C). Following the completion of this program, participants will increase their self-efficacy and knowledge about what are microaggressions and how to combat them. Moreover, participants may improve their social support and promote an inclusive and welcoming work environment.

Discussion

The Social Determinants of Health

Healthy People 2030 outlines five domains of social determinants of health (SDOH): Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.[25] The TMDH program is designed to target three out of the five domains at a minimum.

It is well documented that educational interventions and programming are effective in creating behavior change.[26] Education Access and Quality is a focal point of TMDH. Both prongs of the program contain an educational component. For HCPs, the workshops are organized to recognize and diminish the occurrence of microaggressions through lecture and role-playing activities. The public will learn about microaggressions either through informational brochures in patient waiting rooms or the informational website displayed on public advertisements.

TMDH targets Health Care Access and Quality through its first prong geared toward health institutions. Educating HCPs about how to identify and combat microaggressions, may mitigate poor patient experiences. Discrimination has been linked to poor health care delivery due to both patient and physician bias.[27,28] It is noted that some individuals may avoid seeing a physician entirely out of fear of discrimination. By alleviating the occurrence of microaggressions and correctly addressing them, HCPs can conduct high-quality care and therefore be more comforting to the patient.

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Social and Community Context encompasses the relationships individuals make whether in their home, school, work, or community. Lack of social support can make precarious situations worse—whether in an unsafe environment or racism and discrimination.[25] Positive relationships and experiences can encourage more welcoming and inclusive environments. In addition to addressing microaggressions, TMDH aims to foster social support among employees in the participating health institutions through their interactions in workshops.

Health Inequity

Microaggressions are a byproduct of larger systems of health inequity. Studies show that experiences of discrimination, such as microaggressions are likely to increase the risk of adverse health outcomes.[12–15] By educating HCPs and the public about microaggressions and its consequences, TMDH strives to minimize such occurrences in patient-physician interactions. Workshops conducted within participating health institutions allow for safe and open conversation among HCPs. By allowing such conversations, microaggressions can be prevented and in turn promoting improved health outcomes and health care delivery for both HCPs and patients.

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Appendix A. Targeting Microaggressions in Delaware Healthcare (TMDH) Logic Model

Goal		Implementation Activities/Objectives	Short Term Deliverables	Mid Term Outputs	Long Term Outcomes
Define & Structure	1	Survey Delaware hospitals & health offices interest in program for new and current hires	4/2022 - Primary outreach to health institutions	5/2022- Interested institutions representatives attend informational meeting	
	2	Establish workshop framework for health institutions	4/2022 - framework created	5/2022- framework & goals shared with institutions	6/2022- institutions send feedback/comme nts/concerns
Identification & Engagement	1	Pre-program survey about microaggressions sent to participating Health Care Providers (HCPs)	6/2022 – pre-survey sent to health institutions and clinics in Delaware	7/2022 – responses collected	Survey sent as new participants are onboarded; responses analyzed and utilized to drive workshops
	2	Informational brochures created to disperse at health institutions	5/2022 – 1000 brochures created	6/2022- Brochures given to 50 institutions in Delaware	Brochures are given to more institutions as

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					they join program
	3	Institute didactic lecture & role-playing workshops	6/2022- Workshop activities/lessons finalized	7/2022- Two workshops per month held	HCPs utilize what they learned in future interactions
	4	Post-program survey about microaggressions sent to participating HCPs	8/2022- Post-survey sent one month after workshops	9/2022- Responses collected	Responses analyzed & used for improvements/ feedback
Marketing & Advertising	*1*	Design advertisements for buses and billboards about the program/ website	4/2022- Ad designs completed	5/2022- Ads posted	Public is aware of website & features
Website Design	1	Create an informational website about microaggressions (including survey) for the public	4/22- website created	6/22- generate 10k website clicks -1k survey responses	8/22- generate 100k website clicks -10k survey responses
Financial Support	1	Seek alternate funding streams (hospital, pharmacy, insurance companies) to offset costs		3/2022 - extra funding is obtained to offset costs	

Appendix B. Targeting Microaggressions in Delaware Healthcare (TMDH): Online Pre and Post-Survey

This survey will take 10-15 minutes to complete. Your answers will aid the research team in understanding the occurrence of microaggressions in healthcare and properly educating Delaware medical professionals. No answers are wrong so please share your experience and opinion to the best of your ability.

Some questions are derived from Deloitte's *2021 DEI Transparency Report*.[29]

Demographics

1. Gender Identity
2. Race & ethnicity
3. Age
4. Occupation
5. Company name
6. Any other identifying information that you wish to include (sexual orientation, religion, marital status, veteran or active military, disability status, national origin, etc.)

Microaggressions

7. What is your definition of the term "microaggression"?
8. Have you been the recipient of a microaggression at your workplace?
    a. Yes
        i. When did this occur?
        ii. Without saying any names, explain the event.
    b. No
9. How often are you the recipient of microaggressions?
    a. Never
    b. Rarely
    c. Unsure
    d. Sometimes
    e. Frequently
10. Have you witnessed a microaggression at your workplace?
    a. Yes,

        i. When did this occur?
        ii. Without saying any names, explain the event.
    b. No
11. How often do you witness a microaggression?
    a. Never
    b. Rarely
    c. Unsure
    d. Sometimes
    e. Frequently
12. Has the occurrence of microaggressions negatively affected mental health?
    a. Yes,
        i. How so?
    b. No
13. Has the occurrence of microaggressions negatively affected your physical health?
    a. Yes,
        i. How so?
    b. No
14. Has the occurrence of microaggressions negatively affected your ability to perform job-related tasks?
    a. Yes,
        i. How so?
    b. No
15. How confident are you in your ability to address biases and microaggressions in the workplace?
    a. 1) extremely unconfident → 3) somewhat unconfident → 5) neither confident nor unconfident→7) Somewhat confident→ 10) extremely confident

Please rate your response to the following statements:

16. My workplace fosters an inclusive and welcoming environment.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree

e. Strongly disagree

17. My workplace provides opportunities to connect with and learn about others who have different backgrounds, identities, and experiences.

    a. Strongly agree

    b. Agree

    c. Neutral

    d. Disagree

    e. Strongly disagree

18. I can be myself at work.

    a. Strongly agree

    b. Agree

    c. Neutral

    d. Disagree

    e. Strongly disagree

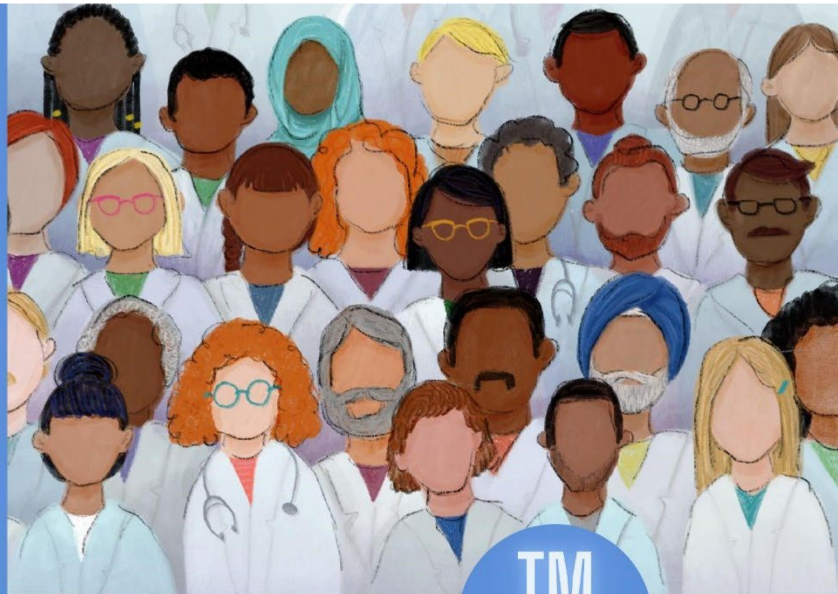
19. What initiatives or programs, if any, are you aware of that your company fosters an inclusive workplace?

Thank you for completing this survey.

Appendix C. Informational Brochure

What are Microaggressions?

A microaggression is a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority).



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