From Eggshells to Action: A Qualitative Study of Faculty Experience Responding to Microaggressions Targeting Medical Students

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Abstract

Purpose

Microaggressions targeting clinical learners cause harm and threaten learning. Clinical supervisors can be powerful allies by intervening when microaggressions occur. This study explored general and student-nominated skilled supervisors' perspectives on responding to microaggressions targeting clinical learners.

Method

This single-institution, qualitative study within a constructivist paradigm explored faculty supervisor experiences with bystander response to microaggressions targeting learners. Clinical supervisors in medicine and surgery departments and those across departments nominated by students as skilled microaggression responders were invited to discuss microaggression scenarios targeting students in semistructured focus groups in the U.S. in 2020–2021. Investigators applied the framework method of thematic analysis to identify themes.

Results

Forty-two faculty (31 medicine and surgery ["general"], 11 "student-nominated" as skilled responders) joined 10 focus groups (6 "general," 3 "student-nominated," 1 mixed). Four themes characterized experiences responding to microaggressions targeting learners: *bystander goals*, *noticing*, *acting*, and *continuous learning*. Participants' response goals were protecting learners, safeguarding learning, and teaching microaggression response skills. Noticing was influenced by past experiences with microaggressions and acculturation to clinical environments. Bystander action stemmed from (1) microaggression type, (2) personal emotional vulnerability, (3) knowledge of student preferences for supervisor response, and (4) clinical and educational context. Bystander action was more common when participants regarded all microaggressions as harmful, understood student preferences for faculty response, expected to err (growth mindset), and framed microaggressions as opportunities for humble reflection, intellectual candor, and teaching. Microaggression response required continuous learning through informal and formal skills development.

Conclusions

Complex factors govern faculty bystander response to microaggressions targeting clinical learners. Efforts to strengthen faculty bystander response should incorporate skill-building around preemptive discussions with learners and using intellectual candor to promote psychological safety, learning, and bystander action. Additional investigation is needed on how to incorporate these skills into team workflows and to assess outcomes of specific response strategies.

Microaggressions in clinical learning environments undermine students' experiences of belonging and safety needed for optimal learning and meaningful institutional diversity. Microaggressions are commonplace verbal, behavioral, or environmental indignities that communicate hostility or negative attitudes, regardless of intention, toward targets' identities.[1] In clinical environments, patients, faculty, staff, and learners may be sources of microaggressions. Patient microaggressions toward learners are increasingly recognized sources of inequity in the clinical learning environment due to frequency, awareness of harm, and concern that responding may jeopardize the therapeutic alliance with patients.[2–5] Existing literature addressing patient microaggressions includes expert commentaries and trainings on response approaches emphasizing observation, inquiry, sharing opinions, feelings, microaggression impact, and requests for next steps.[6] However, a gap remains in understanding how faculty implement microaggression response skills in clinical settings.[6–8]

Interpersonal microaggressions manifest as microinvalidations, microinsults, or microassaults (Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B459).[1,9] Microinvalidations minimize or dismiss the target's experience. Microinsults offend or demean the target, often unwittingly. Microassaults, the most egregious, are verbal or behavioral attacks. Microaggressions may be subtle and unnoticed by bystanders, or overt. *Micro* reflects the interpersonal nature of the interaction, not the size of the impact, and is conceptually distinct from *macro*aggressions which comprise purposeful systemic or structural violations.[10] In addition to the microaggressor (*source*) and the person experiencing the microaggression (*target*), microaggressions are often witnessed (*bystanders*).[11]

In clinical team settings, supervisors are often bystanders when patients microaggress learners. Women and

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people of color are disproportionately targeted.[4] Shifting medical student demographics away from White male over-representation toward increased numbers of women,[12] sexual and gender minorities,[13] and students from racial and ethnic groups historically excluded from medicine[14] have increased the number of students likely to experience microaggressions. Medical student targets may suffer psychologic and physiologic distress, increased cognitive load, and activated stereotype threat which can impair learning and task performance with cascading consequences for professional trajectory.[2,4,15–18] In our study of student preferences for supervisor response to microaggressions, students echo prior work describing that supervisor inaction may compound microaggression injury and disempowerment, eroding learners' trust in their supervisors when they most need support.[19–21]

Despite their empowered position atop the medical educational hierarchy,[22,23] faculty experience discomfort talking about racism, discrimination, and microaggressions with trainees.[7,24] Many describe a feeling of walking on eggshells talking about race and bias or fear reputational threat that thwarts conversation.[25] Bystander faculty may share the targeted identities being microaggressed or experience racial battle fatigue from navigating frequent microaggressions, which may hinder response.[7] These barriers are contextualized in a broader sociopolitical reckoning with racism in the United States (U.S.) in the wake of murders of Black individuals and COVID-19 pandemic inequities, which have amplified existing calls to address structural and interpersonal racism.[14,26,27] Understanding how faculty implement bystander microaggression response skills may offer insights to support bystander action, which students previously identified as important.

In this study, we explored supervisors' experience, considerations, and techniques used to respond as bystanders to patient microaggressions targeting clerkship students. We enriched our sample to include faculty identified as skilled responders by students from our prior study examining clerkship student's perception of ideal faculty bystander response to patient microaggressions targeting them.[19]

Method

Design

This qualitative focus group study was based in a constructivist paradigm. We used the framework method of thematic analysis[28] to explore supervisor experiences and perspectives responding to microaggressions as bystanders, and facilitators and barriers to responding, at one U.S. medical school.

Our research team included a South Asian medical student, a Black resident, and 5 faculty (3 White, 1 Indigenous/White, 1 South Asian). All were from the University of California, San Francisco (UCSF) School of Medicine, with prior research in the experiences of minoritized learners. Four faculty are in the Department of Medicine, 1 Department of Surgery, and all 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 large public institution with 3 core teaching systems (quaternary university system, public safety net hospital, veterans' affairs medical center). We invited faculty from the Departments of Medicine and Surgery who supervised students over the preceding year (November 2019–November 2020) to capture experience across diverse clinical contexts ("general"). To enrich our data, we purposively invited faculty identified as skilled responders to microaggressions by students in our prior study[19] exploring student perspectives on ideal supervisor bystander response to microaggressions targeting learners ("student-nominated"). All Medicine and Surgery faculty who supervised medical students on core clerkships as identified by requests for medical student evaluations and all student-nominated faculty were eligible and invited to participate with 3 weekly email invitations. The invitation directed respondents to a Qualtrics web platform to enter their demographics (gender, race/ethnicity, self-identification as Lesbian/Gay/Bisexual/Queer, and rank), email address, and availability. All responding faculty were invited to a focus group if 2 or more faculty were available simultaneously. Participants received a $20 gift card.

Data collection

We conducted semistructured focus groups over Zoom, November 2020–January 2021. The moderator presented up to 4 microaggression scenarios targeting learners, representing 3 interpersonal microaggressions types (Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B459) as prompts to discuss participants' experience responding to microaggressions. Scenarios, developed based on literature review and team members' lived experiences, were identical to those in our prior student study and depicted a student microaggression target and faculty bystander in inpatient or emergency department settings.[1,19] Following the initial focus group, we revised the guide to improve clarity and reduce redundancy (Supplemental Digital Appendix 2 at http://links.lww.com/ACADMED/B459). The moderator (M.T.O.) first defined microaggressions and informed faculty of the purpose to create faculty trainings on how to respond to microaggressions. Questions explored faculty perspectives on potential bystander responses, perceived facilitators and barriers to responding, preparatory discussions (identified by students in our prior study as important), and personal experiences intervening upon microaggressions. Five of 10 focus groups had a co-facilitator (J.L.B., S.A.R., K.L.L., K.E.H.) to take notes and keep time; co-facilitators were not available for all groups. Data collection ended after all interested and available faculty participated. The virtual format optimized participation, though may have shifted interpersonal group dynamics. By the final focus group, no new major ideas or response strategies were discussed, indicating sufficiency of themes and data collected.[29] All groups were professionally transcribed and de-identified before analysis.

Analysis

Four researchers (M.T.O., J.L.B., P.K.M., K.E.H.) independently read 3 transcripts to familiarize and identify ideas and concepts in the data. The research team then met to discuss their proposed codes and created a single

codebook. Next, pairs of researchers (M.T.O., J.L.B., P.K.M., P.J., S.A.R., K.L.L., K.E.H.) separately coded each transcript and reconciled discrepancies through discussion. We used Dedoose Version 8.0.35 (Los Angeles, CA) to organize and retrieve coded data. After sorting coded excerpts by microaggression scenario, we synthesized excerpts by code for "general" and "student-nominated" participants for each scenario. We charted each synthesis into the final framework matrix which held participant type for each microaggression scenario by code (column by row) using Microsoft Excel Version 16.44 (Redmond, WA).[28] Through iterative data review and discussion, we identified themes and revisited the coded excerpts to verify that identified themes reflected the data.[30] All researchers participated in the final interpretation and data summary. We indicate participants' self-identified gender and race/ethnicity alongside their quotations.

Reflexivity

Two researchers (M.T.O.) and (J.L.B.) who worked together on a clinical team and reflected on their response to microaggressions targeting medical student team members conceptualized the project with other investigators. Concurrently, amidst increased institutional training to shift culture toward greater inclusion and belonging, M.T.O. encountered clinical educators who described the feeling of walking on eggshells when responding to microaggressions, which informed the research question. To engage in reflexivity,[31] the researchers frequently reflected in pairs or a group[32] on observations from faculty focus groups, personal experiences being microaggression targets, preparing for and responding to microaggressions targeting learners, and discussions with colleagues about bystander response experiences. We considered our own positionality: role (student, resident, faculty), specialties, and identities. M.T.O. kept written reflections following focus groups.

Credibility

We shared a draft of synthesized, analyzed results by email with all study participants to query whether the results felt consistent with their experiences and focus group discussions.[33,34] Eleven participants responded and agreed that the information accurately represented their focus groups with no changes needed.

Results

Three hundred forty-seven faculty received focus group invitations; 53 responded (15%). We conducted 10 focus groups with 42 faculty: 31 "general" and 11 "student-nominated." Ten general and 1 student-nominated faculty could not schedule due to availability limitations. Focus groups included 2 to 5 faculty each and lasted on average 58 minutes (range: 55–69 minutes). Six groups were "general," 3 "student-nominated," and 1 mixed. Thirty participants were from Medicine, 9 from Surgery, and 3 from other departments (student-nominated). Table 1 shows participant demographics. The general group had a slightly higher percentage of participants who identified as heterosexual or White compared with the student-nominated group.

All groups recognized the microaggression in each scenario and shared personal experiences with similar microaggressions on clinical teams. We identified 4 themes and associated subthemes from participant reflections on the scenarios and personal experiences responding to microaggressions targeting learners: *bystander goals*, *noticing*, *acting*, and *continuous learning*. General and student-nominated participants shared many similar perspectives; where present, we highlight distinctions between groups.

Bystander goals

Participants' motivations for responding to microaggressions were rooted in their professional responsibilities as educators, personal experiences being targeted by microaggressions, and/or awareness of personal privileges that compelled action. They described 2 main goals of response: *safeguard the learner* and *protect and promote learning*.

Safeguard the learner. Participants identified microaggressions as threatening students' psychological safety. When considering whether to respond, participants identified the complex balance between their dual role as clinician to a vulnerable patient and teacher to a vulnerable student: "It's always that struggle of, who am I protecting.… I have to make sure the target of the microaggression is being taken care of" (26 student-nominated, Asian woman). They sought to support the student, minimize psychological harm, provide corrective interventions to minimize microaggression recurrence, and maintain patient and team relationships.

Protect and promote learning. Participants regarded microaggressions as intrusions on clinical learning. They wanted to model skillful response for students to turn microaggressions into a learning moment. Many feared unskillful responses cause disruptions to learning or harm students or patients. One described, "I care much less about if I do it perfect for the patient [microaggressor] … It's actually the role modeling in front of students … you would want to do it right" (17 general, White woman). Student-nominated participants described microaggressions as an opportunity to contextualize structural bias and teach responding as a professional skill by modeling quality responses, recovery after unskillful responses, and humble reflection.

Participants observed that students wanted to learn response skills and students' capacity to respond to microaggressions increased with level of training: "I've been really surprised at how many learners want to stay involved in hard situations, actually, or at least, want to go back with me for the hard conversation …, sometimes, that's the thing they want to learn the most, actually, is what do you do next?" (24 student-nominated, Latina woman). Student-nominated faculty leveraged this trajectory to enhance student learning by tailoring their bystander intervention to trainee level (more protective interventions for more junior learners) or to previously discussed student learning goals.

Noticing

Participants emphasized noticing and being alert to microaggressions as prerequisite to responding. Recognizing microaggressions required awareness of team members' physical cues such as uncomfortable body language, darting eyes, or backing away: "Any kind of awkward silence in the room

Table 1

Descriptive Demographics of Faculty Participants From the Departments of Medicine and Surgery (General) and Participants From any Department Nominated by Students in a Prior Study[19] as Skilled at Responding to Microaggressions

Participant demographic	Number general (% of general)	Number student-nominated (% of student-nominated)
Total	31 (100)	11 (100)
Department		
Medicine	22 (70.9)	8 (72.7)
Surgery	9 (29.0)	0 (0)
Other	0 (0)	3 (27.3)
Gender		
Female	20 (64.5)	7 (63.6)
Male	10 (32.2)	4 (36.4)
Nonbinary	0 (0)	0 (0)
Prefer not to answer	1 (3.3)	0 (0)
Race[a]		
American Indian/Alaska Native	0 (0)	1 (9.1)
Asian	5 (16.1)	4 (36.4)
Black or African American	1 (3.2)	1 (9.1)
White	20 (64.5)	5 (45.5)
Prefer not to answer/not listed	5 (16.1)	1 (9.1)
Ethnicity		
Hispanic/Latinx	2 (6.5)	2 (18.2)
Not Hispanic/Latina	27 (87.1)	9 (81.8)
Prefer not to answer	2 (6.5)	0 (0)
Orientation		
Heterosexual	27 (87.1)	8 (72.7)
LGBTQ	3 (9.7)	3 (27.3)
Prefer not to answer	1 (3.3)	0 (0)
Rank		
Assistant	14 (45.1)	4 (36.4)
Associate	6 (19.4)	2 (18.2)
Professor	9 (29.0)	3 (27.3)
Emeritus	1 (3.2)	0 (0)
Other	1 (3.2)	2 (18.2)

Abbreviation: LGBTQ, lesbian, gay, bisexual, transgender, queer.
[a]Participants were asked to select all that apply, so categories add up to more than 100%.

is a clue, body language can tell you a lot … they may recoil or make a face" (34 general, White man). The fast pace and prioritization of clinical care made noticing challenging.

Participants' personal and prior professional microaggressions experiences affected their ability to notice and respond. Holding privileged identities (male, White, cisgender, heterosexual, able-bodied, etc.) could limit noticing microaggressions targeting other identities. Prior experiences being targeted sensitized some participants to notice similar microaggressions targeting learners. Conversely, others, particularly women general participants and surgeons, felt their training conditioned them to endure and minimize frequent microaggressions. This survival mechanism diminished their noticing similar microaggressions targeting learners despite universal desire for a less abusive culture. One participant described her "skin of perpetual thickness" (21 general, White woman) when recounting an experience in which a male resident noticed a gender-based microaggression targeting a female trainee that she did not. Another described, "I'm an immigrant to this country.… I just learned to tune them out, so to speak.… So I need to relearn how to pick up on those things" (15 general, Asian man). Participants cited regional, clinical, and generational differences constraining ability to notice microaggressions, and their own experience training in environments that centered the patient as always right, normalized or discounted microaggressions, or viewed those affected as weak.

Within focus groups, several student-nominated participants with privileged identities acknowledged their identity-related positionality, how it might impact focus group dynamics, and deferred responding until others spoke.

Acting

Participants described factors that influenced their response to microaggressions: *microaggression evaluation*, *vulnerability*, *student preferences*, and *context* (Table 2). Student-nominated participants tended to respond while general participants' experience was more heterogeneous. Effective responses honored student preferences, supported student agency, maintained relationships, and minimized microaggression recurrence. Responses varied by microaggression type (Supplemental Digital Appendix 3 at http://links.lww.com/ACADMED/B459) and were adapted to participants' personal style and practice.

Microaggression evaluation. Prompted by provided scenarios (Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B459), participants described how microaggression type and perceived microaggressor intent influenced their response threshold. Microassaults, the most flagrant microaggression type, provoked strong emotions and warranted immediate, direct intervention, provided responding would not escalate the patient's behavior or provoke violence. Microinvalidations were described as more nuanced and complex due to the intersecting team dynamics and educational hierarchies in our scenario. For microinsults, participants diverged in their experiences responding. Participants who perceived benign intent, minimal impact, or patient resistance to corrective intervention felt uncertain, with some avoiding responding: "If it's some person from a different generation, I'm just not sure what we are accomplishing if the recipient is not recoiling or having a negative reaction" (33 general, Asian

Table 2

Factors Influencing Faculty Bystander Action in Response to Microaggressions Targeting Clerkship Students and Representative Quotes

Factors	Representative quotes
Microaggression evaluation	
Microaggression type: Response approach differed by microaggression type. All faculty had strong reactions to microassaults, the most flagrant, intentional microaggressions, which warranted immediate direct action. Microinsults and microinvalidations prompted more varied responses. Participants described greater familiarity with microaggressions targeting certain identities, depending on their personal experience.	This one is one that I know that I would find triggering. And I can say, historically, for this one, honestly, I don't know that I would even look to a learner, I would probably address it, again, because it's an aggression against me at this point. (4 student-nominated, Black, Hispanic/Latino man)
	I'm probably attuned to particular types of microaggressions more than others. I think based on different places where I worked in residency, I think because gendered microaggressions are so common. (30 general, White man)
	In contrast to the first scenario, there's something about this one that feels more like you just want to go in as a lion a little bit more. (40 general, Asian woman)
Intent: Participants' perception of the microaggressor's intent influenced responses. Faculty who described using their perception of intent to determine whether to respond, were less likely to respond to microinsults or invalidations, when they perceived intent as benign. Faculty who understood all microaggressions as harmful, instead used intent to calibrate response. Intent was interpreted in the context of the patient–provider relationship, patient's identities, and generational, religious, and socioeconomic norms.	One of the things I've been trying to work on is shifting away from like, "Okay, what is in the heart and mind of this person?" towards like, "What is the impact of this behavior?" And really focusing on impact…. We're not really going to move the needle on a lot of people's core beliefs and values and implicit biases, et cetera, but we may be able to say, "This is what's acceptable in this room and in this environment. And if you're going to be here and receive care from us, then these are the set of behaviors that we need you to follow." (12 general, White woman)
	There are times when there are pervasive patterns with patients. I mean, one of the primary groups that I practice with … their brains literally aren't working very well. And they can sabotage their own care without meaning to…. And let's hold that with compassion and also understand the impact of their actions. (24 student-nominated, Hispanic woman)
Vulnerability	
Strong emotions: Participants recalled strong emotions, including anger, shock, disorientation, or trauma responses related to past experiences being targeted by similar microaggressions, which could impact their capacity to respond as bystanders. Having low emotional reserve (i.e., fatigued, hungry, stressed, etc.) make real-time response more difficult.	If it catches me completely by surprise, and I'm sort of on my heels, like whoa, God, I hadn't expected that and I'm stymied and I don't have anything to say and I'm sort of within that sympathetic overdrive, fight, flight, freeze situation. (3 student-nominated, Asian man)
	The other factors I consider just in myself are time of day, last time I had a situation like this, other things that might trigger me, how tired I am, just to gain a quick pulse on am I just a little bit jumpier than usual? (4 student-nominated, Black, Hispanic man)
	There are times where I don't feel like I have the bandwidth to address a microaggression for some reason…. I'm literally not emotionally regulated enough in that moment to do it because I'm so upset. (24 student-nominated, Hispanic woman)
Discomfort: Participants described discomfort with confrontation and discussing race. They felt pressure to "get it right," and imposter for not knowing how to respond skillfully despite being the positioned as the most knowledgeable person in educational hierarchies. Having a repository of responses to use when experiencing discomfort, expecting to make mistakes, and anchor in humility facilitated response.	Having a toolbox of specific words or phrases that you can go to is really helpful…. I was an English major, but that doesn't mean I'm going to be able to find words when I need them. (2 student-nominated, White woman)
	I really am not good or comfortable with addressing something in the moment or having the right words or being able to identify that something really is happening that's like … that processing in my head. (23 student-nominated, Asian woman)
	I still struggle with the pressure of saying the right thing, but I have to anticipate that it will rarely be the case that what comes out in the heat of the moment feels like it was the right thing…. (35 general, White woman)
	I think I'm much more paranoid that I'm going to screw up and say something wrong, especially around race. (40 general, Asian woman)
Risk: Participants weighed the risk of responding. Risks included inadvertently microaggressing, exposing their own assumptions or biases, or responding unskillfully, causing harm to the patient (injuring the therapeutic alliance, provoking feelings of shame), the student (escalating the patient, eroding student agency by responding when response is not desired), the team (fractured relationships), or themself (reputation).	Because part of the calculus is also will this person understand my correction or my acknowledgment in the moment? And if they understand it, will it have either a positive or negative impact? (1 student-nominated, Asian man)
	My instinct too is to think about who this patient is, how vulnerable they are…. But then, there's that tension of protecting the learners or yourselves, or self-respect and dignity of everyone in the room. And so, I think that is a tension and that … and I agree, in a very acute situation, de-escalation is often the priority. (23 student-nominated, Asian woman)
	I feel at risk of embarrassing them further or rubbing salt into the wound as the issue of bringing this up. So, I don't bring it up. Because I've had the experience of bringing it up and making it feel like just wasn't a resolvable issue. And I wasn't being supportive, I was just making it worse or making the person feel worse. (28 general, White man)
	I take pride in my role as a teacher, and a clinician, and to feel like despite that, I can still make … an honest mistake with the best of intentions and intent sometimes doesn't matter. (40 general, Asian woman).

(*Table continues*)

Table 2
(Continued)

Factors	Representative quotes
Confidence in response skills: Participants often felt unprepared to respond skillfully, though some felt their identities and lived experience helped them be prepared.	We don't know what we don't know, that makes it more complicated. (3 student-nominated, Asian man)
	As somebody who identifies as a White person, I worry more about sticking my foot in my mouth, and not doing the right thing. Whereas when it's around gender, I feel more comfortable with that, I think, because I feel like it's something that I've personally experienced. (42 student-nominated, White woman)
Student preferences	
Inferred: Participants inferred student preferences for bystander action based on verbal and nonverbal cues and perceived microaggression impact on the learner. Many acknowledged the pitfalls of inferring due to cues being impacted by educational hierarchies and expectations of professionalism.	There's reading the room and just sort of physical and verbal cues, so I think if I see the student at who this directed basically become uncomfortable or darting away eyes, showing anxiety or any sort of behaviors that sort of alter the dynamic of the room, then I feel like that signals that something has changed that needs to then probably be addressed before we leave the room. (13 general, Asian woman)
	If the student responds, then I would take cue from them. So, if they respond in a manner that suggests that they're offended, I would acknowledge that with the patient and say, "This is not an appropriate comment," but if they laugh it off, then I wouldn't change the direction of the conversation towards a more aggressive stance. (15 general, Asian man)
Directly elicited: Some participants assessed student preferences for bystander response in advance, which facilitated bystander action.	I ask why, how people want me to respond, because I also don't want to take away their agency to speak up for themselves and be that like the White knight complex sort of thing. (34 general, White man)
	The last 2 times I attended, we talked about microaggressions as part of day 1, like meeting each other and setting expectations for the month. And that helps so much … it's made me more effective in addressing. It's still really hard. It's still really stressed out a lot about it when they happen, but I feel more comfortable and capable in my role as the attending, having talked about it and set the stage from the start. (35 general, White woman)
Clinical context	
Patient condition: Participants prioritized providing care to clinically unstable patients and deferred microaggression response until patients were stable. They questioned whether patients incapacitated by intoxication, psychiatric decompensation, or delirium could meaningfully receive corrective intervention, though they sometimes responded anyway to signal support to students.	The perspective taking of, "Wow, this person is sure lashing out and also maybe they're intoxicated and maybe they don't have a frontal lobe anymore." And so, I think those things, I'm not sure they get in the way, but they certainly shape how I respond and how hard I try to respond in a way that is attempting to change the patient's…. (2 student-nominated, White woman)
	At the same time that this microaggression is happening, you're also trying to understand what [the patient's] signs and symptoms entail, what's going on with them, how sick they are, what interventions would be needed, how quickly will they be needed, whether you have time to do that now or later, and some other patients you might have on the floor who are sick … there's a lot of other stuff that you're trying to deal with. (15 general, Asian man)
Care environment: Participants described that competing demands, fast pace of patient care, team hierarchy, role ambiguity, frequently rotating team members, and large patient loads made responding more difficult.	You have a busy service and surgery is notoriously insensitive to what else is going on. We're actually not insensitive. We are sensitive I guess, but everybody's busy and running around. So, we don't often address [microaggressions]…. (28 general, White man)
	I think one of the challenges here is that you're rounding at the moment, and so a decision I'd have to make is deciding whether to stop rounds then and address it versus setting a time later in the day. And that may depend partly on who would still have to be seen as patients and how urgent that is versus going ahead. (36 general, White woman)

woman). However, student-nominated faculty and some general faculty reported responding to all microaggressions, immediately or afterward, regardless of perceived intent. They used their interpretation of intent to calibrate response approach to preserve therapeutic alliances.

Participants acknowledged perceptions of microaggressor intent and microaggression severity were filtered through their personal experience, beliefs, and biases. To infer intent, they considered patient tone, identities, clinical context, quality of prior patient interactions, and patient–provider relationship. Many participants gave the patient the benefit of the doubt. Delirious, intoxicated, or psychiatrically ill patients seemed less culpable for their behavior. Participants acknowledged that patients are disempowered by illness and may hold marginalized identities that render them vulnerable.

Vulnerability. Participants described feelings of vulnerability that influenced their microaggression response. Emotional vulnerability arose from multiple sources while confronting microaggressions, especially if previously targeted. Responding required emotional reserve, which was eroded by factors such as hunger, fatigue, and stress.

Despite recognition that medical training taught them to tolerate discomfort and act anyway and awareness they should respond to microaggressions, participants struggled to respond if they experienced anxiety they would respond unskillfully or discomfort talking about identity. Some

perceived younger generations as more knowledgeable and skilled at confronting bias and oppression, which triggered reputational threat and imposter syndrome in an environment where supervisors are positioned as experts. For some, a feeling of being on high alert to microaggressions was exacerbated by intensified national discussions about racism, heightening their sense of duty to respond. One described, "Especially, around Black African American trainees, I feel like the stakes are just a lot higher to get it right. I think, unfortunately, that probably interferes with my ability to get it right" (42 student-nominated, White woman). Student-nominated participants reported responding consistently despite their emotional vulnerability, while for general participants, vulnerability inhibited their responses.

Participants undertook a risk calculation weighing the likelihood of their response worsening the situation for patients or learners. Some avoided responding when they feared they would respond unskillfully, stifle conversation, undermine student agency, or microaggress. While all participants wanted to avoid unskillful responses, some, mainly student-nominated participants, acknowledged unconscious biases could cause them to commit or worsen microaggressions and expected to respond unskillfully at times. They used microaggressions and unskillful responses as an opportunity to model responding, for vulnerable reflection, and learning.

Finally, participants felt they lacked experience preparing them to respond to microaggressions, although women and participants of color sometimes felt their identities helped them prepare. "We should be equipped to do this, but none of us were trained to do this, and our students actually are so much further ahead in their understanding and ability to do this" (13 general, Asian woman). Some described the need to unlearn the skill and habit of enduring microaggressions. While both general and student-nominated participants reflected on perceived generational differences in ability to notice and discuss microaggressions, general participants described greater uncertainty navigating this divide.

Student preferences. Faculty attempted to align their responses with student preferences, which many inferred while others directly elicited. Some forwent response if the student ignored the microaggression or laughed it off. Many acknowledged the pitfalls of inferring student preferences from verbal and nonverbal cues, which may be impacted by educational hierarchies, bias, and professionalism expectations.

Many student-nominated and some general participants described preemptive one-on-one or team conversations (pre-briefs) to identify learner preferences for faculty bystander response which allowed them to hone their response threshold. Greater clarity around student preferences facilitated response and eased the emotional vulnerability and perceived risk of responding. One described that pre-briefing removed the guesswork of calibrating his response: "I had a lot more trouble with this stuff before I started doing the prefacing conversation … dialing it in right was the biggest thing … since I've started doing these pre-conversations, it's gotten so much better" (34 general, White man). Those who first encountered pre-briefing during the focus groups were enthusiastic about incorporating it, which was perceived as more difficult in surgical team workflows.

Participants who pre-briefed described key components (Table 3). Pre-briefing enabled faculty to model humility about their own growth and invite feedback and discussion of microaggressions. Student-nominated faculty valued pre-briefing with all learners, regardless of perceived vulnerability to microaggressions, to establish team culture and include those who may have unobvious targeted identities.

Context. Clinical context influenced bystander action. Providing appropriate medical care for acutely ill or decompensating patients superseded any in-the-moment bystander response. Faculty adapted responses by leveraging prior longitudinal patient relationships to offer corrective feedback or scaling back a response to avoid jeopardizing future care-seeking.

Time pressure while tending to the clinical care needs of all patients and educational needs of learners inhibited responding. One participant described: "especially in urgent situations, there's just a lot of conflicting priorities and there's often not a lot of time. Time … is definitely a stressor" (12 general, White woman). Others, particularly surgeons, described challenges of frequently rotating team members, fast-paced teams, large patient loads, and competing priorities. Role ambiguity of who should respond (senior attending or resident team leader) thwarted action. Participants regarded microaggressions from colleagues or team members as more challenging than from patients due to ambiguous power differentials and need to maintain working relationships.

Continuous learning

Participants viewed responding to microaggressions as a professional competency not taught in their training, but which improved with formal education, practice, and improved awareness. Institutional prioritization of diversity, equity, and inclusion increased focus on skills development. Participants gained skill and confidence through formal faculty trainings, but some noted that trainings heightened their response anxiety. Developing a personal repository of response phrases helped facilitate action. Several commented that they would revise their response approach after participating in the focus group.

Informal learning occurred through discussion and reflection with colleagues and learners. Hearing others' stories increased their capacity to notice microaggressions: "I have my view of the world and I'm able to see what I can see, but just being told by others what they're experiencing as a microaggression [helps]" (4 student-nominated, Afro-Latino man). Learner feedback also improved participants' ability to notice and respond to microaggressions. Some described trainees' influence helping them unlearn to expect gender-based microaggressions as routine when delivering care. Critical self-reflection was a common tool for personal growth: "something that's always on the back of my mind, is, how am I failing all the time without realizing it?" (25 student-nominated, White man). Participants, particularly student-nominated, often demonstrated humility when discussing microaggressions: "we're seen as the most knowledgeable people in the room and so we'd have to be able to talk authoritatively on it … yet I'm not the authority. I have

Table 3

Approach to Conversations About Microaggressions With Learners: Anticipatory Pre-Briefing and Debriefing, With Representative Quotes Reflecting Language Participants Use and Approach Taken

Approach	Representative quotations
Pre-brief	
Participants who pre-briefed described key components: • *Identify a meeting format* that works for your style and team workflow, one-on-one, or as a team. • *Pre-brief with all learners* regardless of perceived vulnerability to microaggressions, to establish team culture and include those who may have unobvious targeted identities. • *Discuss microaggressions:* They are common indignities targeting identities, from any source, including ourselves, and cause harm (emotional distress and distraction from learning and task performance). • *Frame responding to microaggressions as a professional skillset* that requires practice. Ask what microaggression response skills learners are working on and make explicit they will not be penalized for responding. • *Nonjudgmentally assess student preferences for real-time faculty action* (follow learner's lead, respond immediately as most senior team member, wait for signal, etc.). o If learner does not have clear preference, invite an in-the-moment signal to jump in. o Validate nonresponse as an acceptable choice when targeted. o Acknowledge that preferences may be situation-specific and evolve. • *Nonjudgmentally assess student preferences for follow-up:* Check-in, debrief immediately, later, or not at all, one-on-one or as group, etc. • *Model humility* about own growth, share limitations • *Invite feedback* and discussion of microaggressions, your bystander responses, and unintentional microaggressions. Provide alternate feedback pathway if learner doesn't feel comfortable giving you direct feedback.	• "If there's anything, including something I'm doing that makes you feel uncomfortable, I want you to ideally let me know or if you don't feel comfortable speaking to me, speaking to the senior resident." (4 student-nominated, Black, Hispanic/Latino man) • "As a [names identities], I certainly have experienced microaggressions in these areas … it is something that I'm working on to be able to address … an area of discomfort for me is addressing these things in real time. But I want to always invite you to … if I miss something or if I don't respond in a way that you would want, that we will always be able to debrief, even if it's 3 days later. And you still want to talk about something, and we haven't talked about it, always an open invitation to talk about it." (23 student-nominated, Asian woman) • "If you're willing to share, have you been in situations where you felt like parts of your identity came up in clinical settings in a way that wasn't entirely positive?… If that happens, do you have a preference about how I respond? And if not, we can exchange glances in real time. And that's okay. We'll figure it out and debrief it. And if you do, then I will try to make sure I show up in that way." (25 student-nominated, White man) • "I wish that microaggressions didn't occur. But they do. And when I see one, I will name it…. If I see a microaggression, how do you think we, as a team, can be the best ally for you? Are you somebody who prefers to do … talk about it afterwards? Or are you somebody who is more amenable to just addressing it right away?" (26 student-nominated, Asian woman) • "If I miss it, please let me know. Because I'm still working on this and it's a skill I'm still trying to get better at because you can only see bias and discrimination through your own lens. So, I could certainly see myself missing something that doesn't fit my lens." (34 general, White man)
Debrief	
Participants who de-briefed described key components: • *Check-in with target to* confirm whether they want to debrief (one-on-one or as a team) and when (immediately, at a later time, or not at all). Consider checking in with bystanders who may want to debrief even if target does not since they may also be impacted. • *Lead with vulnerability* by disclosing own emotional response or humble reflection on efficacy of response. • *Discuss what happened.* Acknowledge different perceptions of what constitutes a microaggression. • *Prioritize impact over intent by* naming language or behavior as inappropriate regardless of the perceived intent behind it. • *Contextualize microaggressions* in the larger pattern of bias experiences in health care. • *Educate and reflect* to hone microaggression response and allyship skills, bring awareness to experiences of bias and mistreatment. Highlight what went well. • *Strategize as a team* what to do if microaggression recurs.	• "That was uncomfortable for me…. How was that for you?" (3 student-nominated, Asian male) • "'Is this experience new to you, or is this one that you've experienced before?' … I feel like it's always that they've experienced it before, as well, and so then figuring out how my approach or how this went down, how that felt relative to some of the previous ones, and what did they think went well about it or what were they surprised that was uncomfortable to them, or whatever the case may be." (4 student-nominated, Black, Hispanic/Latino man) • "Hopefully something like this won't happen again, but it probably will, and, so, how can we prepare for the next time?" (5 student-nominated, American Indian/Alaskan Native, White woman) • "I find, sometimes, what I perceive as a microaggression, they may not feel that way … so the first thing out of my mouth … is 'It's so interesting that … there can be a really big divide between intent and impact. And I'm curious, from your perspective, what was the impact of what happened?' so that I can just get a read of, where is my learner in this moment." (23 student-nominated, Asian woman)

to bring some humility to this and let people teach each other" (1 student-nominated, Asian male).

Participants desired to learn frameworks, language, and allyship skills. General participants sought skills development for recognizing microaggressions, pre-briefing, and developing language to respond immediately. Student-nominated participants sought more nuance in their understanding of microaggressions to improve their ability to answer student questions and model responding.

Discussion

This study captures a breadth of faculty experience responding as bystanders to patient microaggressions targeting clerkship students, ranging from inaction to bearing witness, offering supportive interventions during or after a microaggression, or directly acting to interrupt the microaggression (sometimes described as "upstander" action). Our purposive inclusion of student-nominated skilled responders alongside general faculty elucidates effective

bystander approaches. Faculty more likely to take bystander action, especially student-nominated faculty, commonly acknowledge microaggressions and elicit student preferences in advance (pre-brief), expect to err (growth mindset), navigate microaggression ambiguity by deprioritizing patient intent when deciding to respond, and frame microaggressions as opportunities to teach and develop their own response skills. From these findings, we identified objectives for faculty development (List 1) to train bystander approaches aligned with student needs. These objectives expand existing microaggression response faculty development efforts which focus heavily on employing response frameworks.[6]

Our data demonstrate that faculty consider factors that students from our prior microaggressions study prioritized as important for bystander response: patient context, interpersonal dynamics, microaggressions factors, and learner preferences.[19] Like students, faculty find educational hierarchies complicate their experience confronting microaggressions. Whereas students worry that responding might impact their evaluations, faculty atop educational hierarchies shoulder expectations of credibility alongside feelings of vulnerability, disorientation, or unpreparedness to respond. Credibility, necessary to be an effective educator and clinician (or student), is socially constructed and contextual, subject to different pressures and expectations across clinical contexts.[35–37] Participant concern about "getting it right" may, in part, reflect anxiety about maintaining credibility in educational hierarchies, heightened by urgent calls to address racism, perceived generational divides in skill addressing oppression, and emotional fragility often associated with privileged identities. Pressure to maintain credibility in moments of vulnerability can impede bystander action. Importantly, our data suggest that this tension is mitigated by pre-briefing—anticipatory discussions of microaggressions and student preferences for bystander action—likely by enabling participants to establish what constitutes credible action for each learner.

Pre-briefing may set the stage for intellectual candor, another approach participants used to navigate tension between credibility and vulnerability. Molloy and Bearman describe intellectual candor as an improvisational expression of doubts, thought processes, dilemmas, and failures shared to promote collective learning.[35] Displays of intellectual candor invite others' vulnerability and model balance between the *credibility* and *vulnerability* inherent in learning new skills and confronting challenges, and can nurture psychological safety required for learning behavior.[38] Intellectual candor is a primary mechanism by which student-nominated faculty harness learning to support their personal growth and that of students to develop the professional skill of responding to microaggressions. Intellectual candor requires trust as it builds trust.[35] By clarifying educator intent, establishing supervisor interest in student preferences and well-being, introducing the humility of a growth mindset, and inviting feedback and future discussion, pre-briefing can facilitate the trust necessary for future intellectual candour.[19,39] While this approach may not eliminate the common feeling of walking on eggshells, it may help build relationships that will.

Our data also suggest the potential for bystander response to support professional identity formation, or the continuous, active process of integrating professional skills, knowledge, values, and behaviors with preexisting identity and values.[40–42] Participants use bystander response to affirm the target's professional belonging, build response skills, and contextualize the social, political, and cultural forces underpinning microaggressions. They considered microaggression response a professional skill set they want to cultivate. Because microaggressions inherently call into play personal and professional identities, learning to respond may have the dual benefit of strengthening supervisor identity as

List 1

Proposed Objectives for Skills-Based Faculty Development Supporting Supervisors' Bystander Response to Microaggressions Targeting Clerkship Students

Microaggression evaluation

1. Describe the immediate and cumulative harms microaggressions cause those targeted.
2. Prioritize impact (rather than intent) when identifying microaggressions.
3. Anticipate microaggressions by familiarizing yourself with common microaggressions and identities targeted.
4. Preserve the therapeutic alliance with patient by calibrating response approach to perceived patient intent.
5. Adjust your microaggressions response approach to accommodate a patient's clinical condition, prioritizing medical care for unstable patients. If an in-the-moment response is not possible, check-in and debrief (if desired).

Vulnerability

6. Reflect on past experiences confronting microaggressions to identify areas of personal emotional vulnerability and strategies for emotional regulation.
7. Engage in self-care to protect emotional reserve; appeal for workplace structural changes that promote wellness.
8. Cultivate humility and a growth mindset—expect that you will respond unskillfully at times.
9. Identify response strategies for each type of interpersonal microaggression.
10. Evaluate the risk different response strategies pose to learners, patients, team relationships, and self.
11. Develop a repository of responses phrases to use in times of emotional overload.
12. Practice responding to microaggressions scenarios.
13. Identify and practice techniques to repair relationships with patients and learners after unskillful response.
14. If debrief is desired by student, use intellectual candor to offer and invite humble reflection on situation and response approach to transform microaggression occurrences into opportunities for learning and to support professional identity formation.

Student preferences

15. Identify and monitor for verbal and nonverbal cues that signal a learner is in distress.
16. Establish an in-the-moment mechanism for learners to alert you to moments of distress.
17. Develop and use anticipatory conversations ("pre-brief") to assess learner preferences for faculty bystander response before microaggression occurrence.
18. Check-in before debriefing to give the student target agency over next steps.

Context

19. Address role ambiguity of who should respond when residents are positioned as team leaders by discussing team response strategy in advance.
20. Anticipate that fast pace and heavy workloads may limit response capacity and discuss this with teams in advance. Identify opportunities to check in with team members about experience with microaggressions and missed opportunities for response.

ally, and helping learners navigate the at times uncomfortable tension between personal and professional identity that lies at the heart of professional identity formation.

This study has limitations. General participants may be more skilled than average due to topic-related selection bias. "Skilled" was interpreted by students and may not necessarily reflect response efficacy. Compared with our institutional demographics, our participants were more female (64% vs 50% of faculty, 2020). This single-institution study focused on 2 departments may not represent perspectives and experiences of all faculty. We did not address all possible microaggressions, sources, or targeted identities, and we focused on interpersonal action rather than structural responses.

Conclusions

Complex factors govern faculty bystander responses to microaggressions targeting learners. Efforts to strengthen faculty bystander response should incorporate skill-building for preemptive discussions about preferences for bystander response and using intellectual candor to hone both faculty and learners' response skills and support PIF. Additional investigation on how to incorporate these skills into team workflows, and into the efficacy and consequences of specific response strategies on learners and patients, is needed.

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