

SHORT REPORTS ON SIMULATION INNOVATIONS
SUPPLEMENT (SRSIS)

Using simulation to identify and respond to microaggressions

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Introduction

Microaggressions are 'subtle yet harmful forms of discriminatory behaviour experienced by members of oppressed groups' [1]. In a survey of 80 final-year medical students placed in teaching hospitals in Northeast Scotland, 35% reported being the victim of microaggressions while on clinical placement and 46% reported witnessing them. This frequent occurrence of microaggressions experienced by medical students has been reported elsewhere [2].

Not only do microaggressions have a negative impact on the victim, they also impede patient care [3]. Therefore, clinicians should be equipped with communication tools to help them identify and respond to microaggressions. At present, most clinicians working in our local context do not have any formal training. Active bystander training (ABT) is an approach that has been utilized to provide such training to clinicians [4]. This intervention aimed to use simulation-based education to practise communication around microaggressions using the ABT approach with final-year medical students.

Innovation

Firstly, our faculty underwent ABT to familiarize themselves with the theory. Following interdepartmental discussions, the decision to target final-year medical students was made. This was based on proximity to clinical practice and capacity within their busy curriculum. Simulation-based training was selected as an effective tool for delivering the intended learning outcomes.

We developed a 90-minute session that was delivered to 20 participants at a time. Sessions required at least three facilitators. Prior to attending, participants had online teaching at which they were introduced to the principles of ABT.

The session began with an icebreaking activity, aimed at fostering psychological safety followed by a recap of ABT principles.

Afterwards, in groups of five to seven, each working with a facilitator, the participants worked through two scenarios. Each scenario was based on a real-life example of a microaggression as reported by colleagues working locally. The first scenario was a pre-recorded video re-enactment of a microaggression from a racist patient. The second scenario was an interactive scripted re-enactment of homophobic microaggression. In the second scenario, participants volunteered to play one of three roles – a nurse/aggressor, a medical student/bystander or a patient/victim. After completing the scripted portion of the scenario, the volunteer playing the role of the bystander had an opportunity to try and be an active

bystander. Each scenario was followed by a structured debrief in which we discussed different approaches that could be taken as an active bystander.

We finished the session with a whole group debrief. Appreciating that these themes can be extremely challenging, we also offered students and faculty well-being support and contact points.

Evaluation

To evaluate our intervention, we gathered anonymous written feedback from students at the end of each session. Students were asked to rate the session out of five and to provide qualitative feedback. We also asked about the impact participants felt the workshop had on them. Lastly, students were given the opportunity to anonymously share their own experiences of microaggressions in clinical environments. With their permission and collaboration, some of these were used to develop scenarios for future sessions.

Outcomes

Over the course of 2 weeks, 240 final-year medical students were invited to attend our session. We received feedback from 150 (62.5%) of these. The session was well received with an average score of 4.67 out of 5. Key themes that emerged from feedback were that participants found the ABT framework useful and empowering, and that there was an appetite for more sessions like this during their medical training. Other themes highlighted were the importance of allyship and victim support.

Ninety-four per cent of participants reported that the workshop had a positive impact on them. Of the other 6%, many commented on feelings of disappointment and distress at realizing how prevalent microaggressions are within our system.

What's next?

We plan to develop workshops for more students and staff groups within our clinical systems. It is also essential to

deliver similar workshops in different and more diverse communities and to continue to involve participants from a range of backgrounds for faculty and scenario development.

It is always challenging to measure the impact of simulation-based interventions on staff or student well-being. This could be achieved by developing a cohort-type study following a group of students who underwent the training as they progress through their first years as doctors. Hence, we could understand how they are using their new skills and if they are effective at identifying and responding to microaggressions.

Comparing the rate of exposure to microaggressions before and after this intervention could be another research avenue. However, this would be difficult to analyse due to confounding factors such as increased awareness of microaggressions.

In future, it would be pertinent to assess the impact of interventions such as this on patient care. This could be achieved by recruiting patient groups to give feedback on medical students' skills in tackling microaggressions.

Declarations

Authors' contributions

None declared.

Funding

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Availability of data and materials

None declared.

Ethics approval and consent to participate

None declared.

Competing interests

None declared.

References

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Table 1: Reported impact of attending ABT simulation on final-year medical students

Type of impact	Number of students	Percentage of students
Positive	141	94.0%
Mixed – both positive and negative	7	4.7%
Negative	0	0.0%
None	2	1.4%
Total	150	100.0%