Stereotypes and Microaggressions: Racist Subtleties in the Healthcare Setting

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Racism is a broad concept divided into many perspectives, each exhibiting diverse paradigms and disparity of impact. In this paper, racism is defined as the expression of prejudice and discrimination related to the race or ethnic background of an individual, exhibited as less obvious biases and assumptions (Sue et al., 2007, p. 272; Wong et al., 2014, p. 182). This paper explores more elusive forms of discrimination often present in the healthcare setting that can hold detrimental health outcomes for the patient analogous to overt racism. Clinical examples of these phenomena are discussed, along with possible solutions, directed towards both clinicians and patients, that can lead to improved health outcomes of racial minorities. In the healthcare setting, a known power differential already exists between healthcare professionals (HCP) and patients (Nimmon & Stenfors-Hayes, 2016, p. 2). This element with the integration of the dimension of race can manifest as detrimental effects on a patient's wellbeing that range from feelings of inferiority to life threatening outcomes. While HCP might prefer to believe that they are impartial and self-aware, racial biases often go unchecked as they may be expressed in the form of more insidious remarks called microaggressions and may be ingrained within the perpetrator unconsciously (Sue et al., 2007, p. 280). These "subtle" forms of discrimination are as harmful as intentional, systematic oppression, with the only difference being that they are more difficult to confront.

Some of the most common forms of elusive racism expressed in the clinical setting are through stereotyping and the use of microaggressions (Sue et al., 2007, p. 273). Stereotypes are introduced to us very early in life and are reinforced by daily dialogue and actions in the form of microaggressions. We are mostly aware of broader stereotypes and generalizations, notice their presence in conversation, and often propagate them without thinking. Microaggressions are "subtle insults (verbal, nonverbal, and/or visual) directed toward racial minorities, often automatically or unconsciously" (Wong et al., 2014, p. 182). Microaggressions are more difficult to detect in daily speech for the perpetrator, and often to the victim as well, but are still operational indicators of racism.

Common Themes of Microaggressions in the Healthcare Setting

According to Sue et al. (2007), there are nine different themes of racial microaggressions which contain the explicit, bigoted message but are masked by the more socially acceptable, spoken version (p. 276). Many HCP categorize their patients and make assumptions about them based on racial stereotypes that fall into one of these microaggressive themes. For example, HCP may have preconceived notions about the patient's level of understanding of their diagnosis or omit presenting certain treatment options on the presumption that the patient will reject it

(Bonham & Knerr, 2008, p. 4). These assumptions made about patients from different racial backgrounds can jeopardize the health outcomes of the patient and subsequent satisfaction with the healthcare system (Penner et al., 2013, p. 87). Different ethnicities and cultures exhibit varied communication styles and values which can contribute to HCP not being able to adequately assess and treat their conditions (Sue et al., 2007, p. 281). This type of microaggression falls under the theme of "pathologizing cultural values/communication styles," in which the communication style of the dominant white culture is considered the prototype, and any deviation can result in misdiagnosis and poor health outcomes for patients of color (Sue et al., 2007, p. 282). An example of racial disparity thematically connected to "second-class citizen[s]" can be found in the field of cancer screenings, wherein white patients receive preferential treatment over patients of colour (Sue et al., 2007, p. 283). Studies show that women belonging to minority groups are less likely to be asked about family history of breast cancer, in addition to receiving mammogram results later, than white women (Bonham & Knerr, 2008, p. 4). A form of microaggressions called "environmental aggressions" involves the normalization of a dominant white people and culture (Sue et al., 2007, p. 276). In a clinical setting, this disparity can be seen in research participants. Although black and Latino populations comprise 30 percent of the American demographic, they are only involved in six percent of federal clinical trials (Konkel, 2015, p. 299). Not only do these clinical manifestations of racial bias impact a patient's physical health, but they may also deter the patient from seeking medical care, instilling a historically justified distrust of the healthcare system. According to Penner et al. (2013), patients of colour, in this case, black and Latino patients, prefer to see physicians of their own race and report a higher quality and satisfaction of medical care in comparison to seeing a white physician (p. 79).

Possible Solutions for Reducing Instances of Microaggressions

One of the most challenging aspects to overcome with this form of discrimination is that it can be difficult to confront due to its insidious nature and because of the aforementioned provider-patient power differential (Sue et al., 2007, p. 281; Nimmon & Stenfors-Hayes, 2016, p. 2). Not only do white HCP receive limited education and practical knowledge about clients from ethnic minority groups, Sue et al. (2007) postulate that they prefer to avoid confronting their own views and biases (p. 272). Although there are policies put in place that address discrimination of ethnic minorities in the clinical setting, much work still needs to be done to confront the implicit forms of racism (Spencer, 2017, p. 2).

While there is no definitive solution to reduce instances of microaggressions in the healthcare setting, educating both the patient and HCP is an effective start (Levine & Ambady, 2013, p. 873; Sue et al., 2007, p. 273). The implementation of cultural sensitivity training is essential for practitioners; it begins by confronting one's own views regarding this topic, no matter how uncomfortable, as it is far more distressing for the patients subjected to ignorance. Also beneficial to include in training would be recognizing subtle tells of patients that indicate discomfort, such as nonverbal behavior. In a study, subjects who identified emotional expressions of people from other cultures became more accurate at assessing them over time (Elfenbein, 2006, p. 30). This study had also been applied to healthcare students with similar results (Elfenbein, 2006, p. 30). Nonverbal communication can play a significant role in the establishment or downfall of a therapeutic patient-provider relationship; ineffective nonverbal

communication can result in incomplete transmission of information, decreased adherence to treatment, and cause further harm to the patient's health (Levine & Ambady, 2013, p. 873). There are practical strategies for HCP to prevent stereotyping patients in the clinical setting. Literature suggests that exposure to real or fictional examples of people that counter specific stereotypes can decrease the subconscious biases against these groups (Levine & Ambady, 2013, p. 872). In particular, learning about the narratives of patients who have been subjected to racial stereotypes can shift the views of HCP (Levine & Ambady, 2013, p. 872).

The role of the perpetrator is often overlooked in instances of microaggressions; power and privilege can inhibit self-awareness of behavior and actions that could be compromising the health of patients of color (Wong et al., 2014, p. 10). While it remains the responsibility of the provider to confront their own views and implement culturally sensitive care, educating patients to be aware of subtle racial insults and invalidations is key to improving the therapeutic relationship. As Nadal et al. (2017) suggest, "if clients were knowledgeable of the definition and examples of microaggressions, perhaps they could develop better ways of coping with such instances, instead of internalizing their negative emotional reactions" (p. 14). In addition to educating patients for the purpose of increased recognition of microaggressions, it can be beneficial to teach others about the negative consequences they can have on physical health as a method of future prevention (Nadal et al., 2017, p. 14). Being subjected to racial microaggressions poses numerous health risks for patients, and educating both the perpetrators and the targets can improve health outcomes and patient-provider relationships (Nadal et al., 2017, p. 14)

On a broader scale, the proliferation of research about experiences of patients of color in the healthcare setting would acknowledge distinctions between white and ethnic minority groups. However, it is important that microaggressions be included in the research as a form of racism. Often in research studies discussing the narratives of patients of color, only overt racism is included (Sue et al., 2007, p. 283). This can imply that microaggressions, which actually compose most interactions between HCP and patients, are less harmful, which is not the case at all. Sue et al. (2007) argue that experiences of microaggressions must be included in the research data as "[its] absence conveys the notion that covert forms of racism are not as valid or as important as racist events that can be quantified and 'proven'" (p. 283). Because of this concern of potential omission, it is also important to note which type of research studies are more applicable to people of color. The most effective form of data collection seems to be through qualitative methods complemented by a mixed methods approach for this type of research (Harrison & Falco, 2005, p. 262; Sue et al., 2007, p. 273). Possible areas of research could focus on coping mechanisms of patients of color in response to microaggressions they face. After all, facing daily microaggressions is a testament to the resilience of people of color (Sue et al., 2007, p. 283).

Conclusion

Whether it is overt racism or microaggressions stemming from deep-rooted prejudices, racial minorities suffer greatly from the identities attributed to them, especially in clinical settings. Stereotypes commonly associated with patients of color have been normalized and are often reproduced without active knowledge. Racism in the form of microaggressions has been

internalized to the point where groups in power are unaware of the privilege they possess, and contrarily, the injustices that ethnic groups face. Being mindful of privilege, especially for such an observable and socially constructed paradigm as race, is the first step to understanding the issue at hand and the need for change (McIntosh, 1988, p. 2). Open dialogue and awareness of the difference in narratives between white patients and patients of color can lead to increased cognizance and sublimate racial profiling in the clinical setting.

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