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HSC Office of Diversity and Inclusion

Did That Really Just Happen?

by: V. Faye Jones, Associate Vice President Health Affairs/Diversity Initiatives,
Professor and Vice Chair of Inclusive Excellence, Department of Pediatrics

The medicine team including the senior resident, two interns and two medical students, were having a very busy night with multiple admissions coming around the same time. In order to be more efficient the senior resident decided to divide up the work and instructed the medical students to do the initial history and physical on patient X. The two 3rd year medical students entered the room of a 45 year old white male, diagnosed with cancer. After each of the students introduce themselves, the patient said to the white male student, "ask me any questions". He (the patient) then turned and looked at the Black student and told her she could take his dinner tray now. This was one of my experiences during my time in medical school in the mid-eighties.

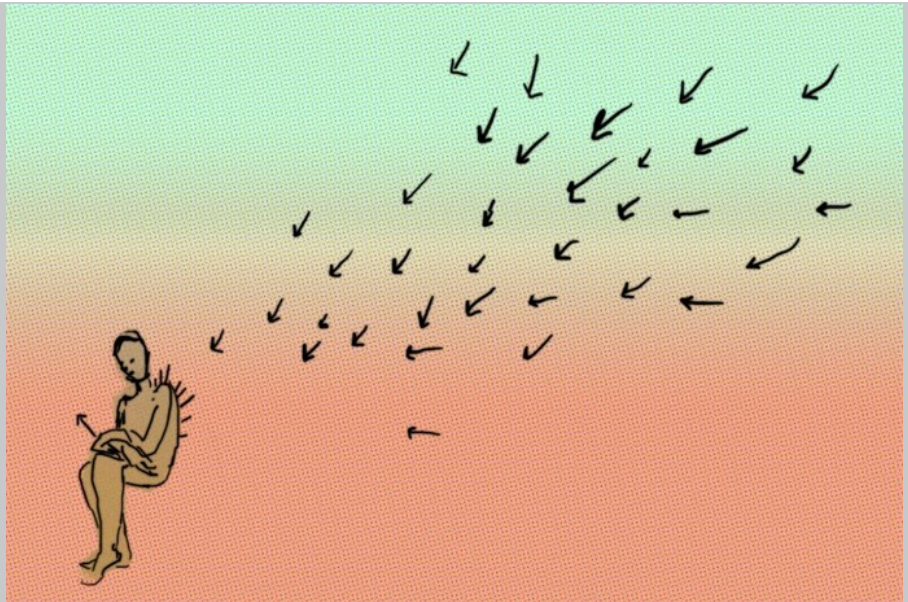Surprising? No. Common place? Yes. Still happening? Yes.

These types of remarks may be experienced every day by those who are considered "different" from the majority group and is an example of a microaggression. The term was first coined by Harvard Professor Chester M. Pierce in 1970, later expanded by Derald Wing Sue. It is defined as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership". In my case, the microaggressive language was based on race, but any of the "isms" (i.e., sexism, classism, ableism, anti-Semitism, ageism, and more) can be substituted in its place. Microaggressions can be divided into three groups: microassaults, microinsults and microinvalidations. (*Table 1*)

The interesting thing about microaggressions is the insidious nature in which it occurs. Persons making the comments may be otherwise well-intentioned and unaware of the potential impact of their words or it may be a conscious act. Either way, it can leave the individual who is receiving these slights feeling oppressed over time. A phrase that describes the impact of microaggressions is "death by a thousand cuts." One little cut really doesn't hurt, but the accumulation of these cuts over time has been shown to have a detrimental impact on health and overall well-being of targeted individuals by taxing their mental and physical resources. Microaggressions have been shown to be associated with increased symptoms of depression, anxiety, and low self-esteem. Experiences of targeted individuals with microaggressions can weaken trust in service providers, which may contribute to poor health outcomes. In the workplace, these experi-

Types of Microaggressions

Microassault - conscious and intentional discriminatory actions against one's identity

Microinsults - unconscious verbal or non-verbal communications that demean a person's heritage or identity

Microinvalidations - communications that exclude, nullify, or negate the experiences or thoughts of a person

Sue and associates, 2007

Table 1

Microintervention strategies

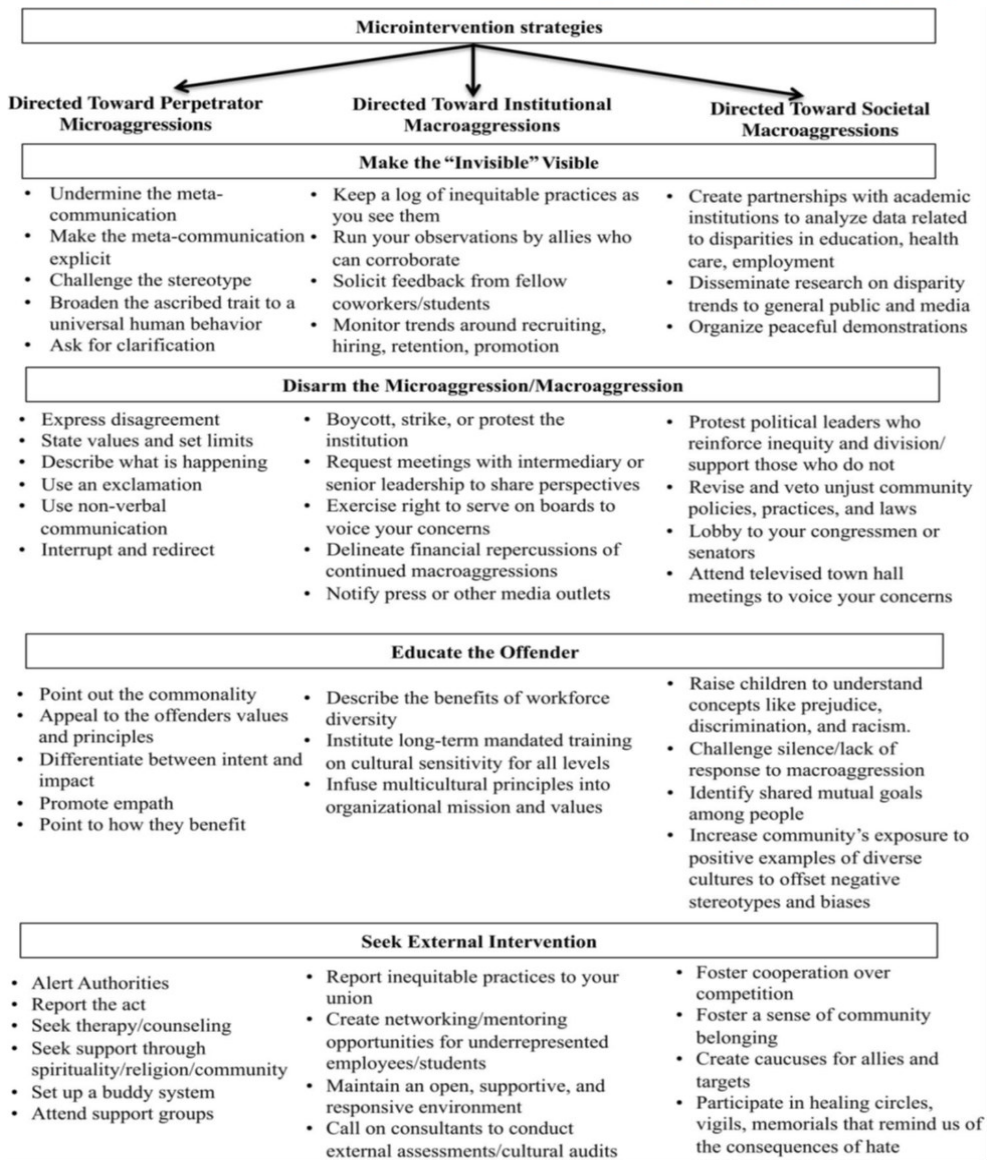| Directed Toward Perpetrator Microaggressions	Directed Toward Institutional Macroaggressions	Directed Toward Societal Macroaggressions
Make the "Invisible" Visible		
• Undermine the meta-communication • Make the meta-communication explicit • Challenge the stereotype • Broaden the ascribed trait to a universal human behavior • Ask for clarification	• Keep a log of inequitable practices as you see them • Run your observations by allies who can corroborate • Solicit feedback from fellow coworkers/students • Monitor trends around recruiting, hiring, retention, promotion	• Create partnerships with academic institutions to analyze data related to disparities in education, health care, employment • Disseminate research on disparity trends to general public and media • Organize peaceful demonstrations
Disarm the Microaggression/Macroaggression		
• Express disagreement • State values and set limits • Describe what is happening • Use an exclamation • Use non-verbal communication • Interrupt and redirect	• Boycott, strike, or protest the institution • Request meetings with intermediary or senior leadership to share perspectives • Exercise right to serve on boards to voice your concerns • Delineate financial repercussions of continued macroaggressions • Notify press or other media outlets	• Protest political leaders who reinforce inequity and division/support those who do not • Revise and veto unjust community policies, practices, and laws • Lobby to your congressmen or senators • Attend televised town hall meetings to voice your concerns
Educate the Offender		
• Point out the commonality • Appeal to the offenders values and principles • Differentiate between intent and impact • Promote empath • Point to how they benefit	• Describe the benefits of workforce diversity • Institute long-term mandated training on cultural sensitivity for all levels • Infuse multicultural principles into organizational mission and values	• Raise children to understand concepts like prejudice, discrimination, and racism. • Challenge silence/lack of response to macroaggression • Identify shared mutual goals among people • Increase community's exposure to positive examples of diverse cultures to offset negative stereotypes and biases
Seek External Intervention		
• Alert Authorities • Report the act • Seek therapy/counseling • Seek support through spirituality/religion/community • Set up a buddy system • Attend support groups	• Report inequitable practices to your union • Create networking/mentoring opportunities for underrepresented employees/students • Maintain an open, supportive, and responsive environment • Call on consultants to conduct external assessments/cultural audits	• Foster cooperation over competition • Foster a sense of community belonging • Create caucuses for allies and targets • Participate in healing circles, vigils, memorials that remind us of the consequences of hate

Figure A; Sund Associates, 2019

ences may be associated with job dissatisfaction, increased employee turnover, and increased amount of lawsuits.

How can we respond to microaggressions? In a recently published article by Sue and colleagues (2019), the authors presented a conceptual framework based on microinterventional strategies directed toward a) individual perpetrator actions, b) institutional programs, practices, and structures, and c) social and community policies. *(Figure A)* The strategic goals of this framework are to:

✓ Make the "invisible" visible. Name it and call it out. "You speak excellent English." The miscommunication is you don't look like me, so you must not be from this country. The microintervention can be simplistic, "I hope so, I was born here."

✓ Disarm the microaggression. This microintervention provides a sense of control. "She only got the job because she is…" The miscommunication is discounting someone's abilities. A microintervention may be to instantly stop or deflect the microaggression. "I don't agree with your view."

✓ Educate the perpetrator. Engage in one-on-one dialogue to indicate how and why what they said was offensive. "I don't see color." The miscommunication is that the perpetrator does not see the person with all the intersectionalities that makes them an individual, or acknowledge their lived experiences based on their identities. A microintervention may be, "I know you didn't realize it but you missed a part of myself that I am very proud to represent."

✓ Seek external reinforcement. Reminds targets, allies, and bystanders they are not alone. "I don't want …taking care of me." The miscommunication is the feeling of not being good enough. A microintervention can be to seek out help from your supervisor. Join a support group.

Although microinterventions are short front lime strategies directed toward microaggressions, they are not the total solution. We all play a role in reducing their occurrences and reducing the impact on its targets. As with anything, we need to practice our responses to enhance our awareness and make it second nature to speak out. This will result in a culture and climate that is inclusive to all.

For training opportunities contact the HSC Office of Diversity and Inclusion
502-852-7159 or hscodi@louisville.edu

Microaggressions in Medicine and the Harms to Patients

by: Lauren Freeman, University of Louisville Associate Professor of Philosophy; and Heather Stewart, PhD Candidate at Western University

Microaggression Stress

1. **Biological and physical effects**
   - Accumulative small changes/stress could be additive--equal to the effect of a major catastrophic trauma.
2. **Emotional effects**
   - "Isms" affect emotional well-being, psychological adjustment, and mental health.
3. **Cognitive effects**
   - Try to make meaning of incidents
   - Disrupted cognitive processing (decreased focus and productivity)
   - Stereotype threat (identity/disengage from interests/under-perform)
4. **Behavioral effects**
   - Hypervigilance /skepticism (suspiciousness toward majority group)
   - Forced compliance (surviving or being co-opted)
   - Rage and anger
   - Fatigue and hopelessness
   - Adaptation to adversity (functional survival skills)

From Sue, D. W. (2010). Microaggressions in Everyday Life: Race Gender and Sexual Orientation. Hoboken, NJ: Wiley.

'Microaggression' is a term that's used a lot these days, especially on college campuses. It refers to routine and seemingly insignificant comments or gestures, sometimes intentional, but mostly unintentional, that convey negative messages to targets, who are members of one or more marginalized groups.

One context in which microaggressions are rarely discussed is clinical medicine. Specifically, few people talk about microaggressions committed by health care providers toward their patients. This is an oversight, one that we're seeking to rectify. We've developed a theory of microaggressions that pays special attention to the ways in which they occur within medical contexts.[1]

Our understanding of microaggressions is unique insofar as it begins from the perspective of those on the receiving end, for our purposes, patients. This approach lies in contrast to the dominant understanding of microaggressions which begins from the perspective of those who commit them, for our purposes, health care providers.[2] More precisely, our work shifts the terms of the debate, arguing for a new understanding of microaggressions based on the vari-

ous kinds of *harm* they cause to targets (as opposed to the kind of *action* committed by the agent, where most of the literatures focuses). We believe that it's imperative to focus on *those who are harmed* as opposed to *those who cause the harm.*

We understand there to be three main types of microaggressions that cause harm to patients, either in their capacity as knowers, emotionally, or with respect to their self-identities. Respectively, and on the basis of their corresponding harms, we call these epistemic microaggressions, emotional microaggressions, and self-identity microaggressions. All microaggressions can occur based on stereotypes about race, gender, sexuality, sexual orientation, age, ability, etc.

The harms of microaggressions are particularly important to pay

attention to within the context of medicine since they accumulate over time, often to the detriment of patients' longer-term interactions with health care professionals, and often unbeknownst to the providers (and others) who commit them. Specifically, routine experiences of microaggressive comments and actions can cause patients to lose trust in their health care providers and even avoid health care contexts altogether.

The consequences of microaggressions can be grave, especially because they combine with other forms of discrimination and marginalization. For this reason, it's imperative that health care providers know what microaggressions are, how harmful and dangerous they can be for patients, and that they take steps to try to avoid committing them.

Let's consider an example of a

microaggression committed by healthcare providers.

Bronte Doyne was a 19-year-old female patient who received treatment for a rare form of liver cancer at Nottingham University Hospitals Trust (in the UK). Months after her treatment was complete and after she'd been given a clean bill of health, she expressed concerns to her medical team that her cancer had returned. Certain that she was overreacting, Doyne's physicians assured her that she was just fine. They even went so far as to instruct her to "stop Googling" her symptoms. In their certainty that Doyne, a young female, was just overreacting and being a hypochondriac, and in their failure to give her claims proper uptake, they also failed to diagnose the recurrence of her cancer in a timely enough manner to have enabled her to receive adequate pain management and cancer care.[3] Doyne ultimately died as a result of her undiagnosed cancer recurrence, 16 months after having her concerns so casually dismissed and being told she'd survive.

So where are the microaggressions? Couldn't we say that this is just a case of gross medical malpractice, or even just a lack of credibility given to the patient? We believe not.

We believe that Doyne's case is best understood as an example of epistemic failure (that is, failure of belief) on the part of the physicians, resulting specifically from the microaggressions they committed. The health care providers committed an epistemic microaggression by failing to give proper uptake to Doyne's claims about her body and symptoms, and in particular her concern that her cancer had returned. Specifically, they made multiple, seemingly subtle comments that expressed that she did not know her own body, or that at the very least, they knew it better than she did. These seemingly small, suggestive comments are paradigmatic of microaggressions.

According to our definition of microaggressions, in order for us to claim that Doyne experienced microaggressions, we must first show that she's a member of a marginalized group. Doyne meets this criterion in two ways. First, she's a patient and within medicals context, all patients can be considered marginalized relative to physicians insofar as they lack power (and often privilege) in the physician-patient relationship. But Doyne is also marginalized in a second way, namely, insofar as she's a *female* patient. It's a known phenomenon that due to pernicious and ubiquitous gender-based stereotypes, within medical contexts, women's claims – in particular, claims of pain – aren't taken seriously, are considered to be over-reactions, and are systematically ignored and/or dismissed. Though this is the case for women in general, it's more serious and widespread for women of color, as well as queer and trans women.[4] As a result, women have diminished status as credible givers of knowledge regarding their bodies.[5]

On account of these two ways in which Doyne occupies a marginalized position, it becomes clear that she experienced microaggressions. Thus, her case isn't just one of medical malpractice or of a failure of attributing epistemic credibility. Rather, the ways that Doyne was treated constitutes microaggressions given the nature of the interactions, namely the seemingly small off-hand remarks and slights, such as questioning whether she'd been "Googling her symptoms again," when really, she'd been experiencing physical changes in her body and pain levels and was trying to make sense of them both to herself, and in a way that would be taken seriously by her medical team. These sorts of seemingly small comments are examples of microaggressions, and we're suggesting that

they're directly tied to her marginalized status as a female and female patient.

So what kinds of harm resulted?

The epistemic microaggressions experienced by Doyne contributed both to serious physical harm (and ultimately, to her death), as well as to significant epistemic harm (and related emotional trauma) for Doyne and her family. The latter can be viewed as a result of their not being listened to, and to their claims about her medical condition not having received proper uptake. These harms could have been avoided had Doyne's physicians taken her and her family's claims seriously at the outset. Consequently, her mother lost trust in health care providers. In reference to their repeated attempts to secure adequate cancer care for Doyne, her mother stated: "I can't begin to tell you how it feels to have to tell an oncologist they are wrong, [but] it's a young person's cancer. I had to. I'm fed up trusting them."[6] When microaggressions are repeated, the long-term distrust that can result can have serious and dangerous physical and psychological consequences.

Consider the case of Xeph Kalma, a transgender woman who brought herself to the ER when she was feeling suicidal, only to experience repeated microaggressions. She describes how she was treated as follows:

In this moment, in my already suicidal state, the doctor has made it a million times worse. I put my coat on and walked out…Instead of having those whom I trust take care of me, those whose job it is to take care of me, I am now at a brand new low – hopeless, hungry, and cold…The way I was treated in the ER – the misgendering, deadnaming, ignorance, and the lack of discretion I experienced – is incredibly dangerous. When I say it was 'my last visit,' I mean it. I will not voluntarily return to an ER the next time I'm feeling suicidal. Anything would be a better option than experiencing that level of embarrassment and shame again. Embarrassment and shame, from those who were meant to take care of me."[7]

The distrust that results from experiences of microaggressions, as evidenced by the cases we've discussed, contributes to patients' doubts about the efficacy of health care, often resulting in delayed medical treatment, foregoing medical treatment altogether, and prolonged illness. These factors can deepen the physical, emotional, and existential harms that accompany illness.

Microaggressions are indeed a large part of a structural problem insofar as there's a long history of gendered and racial epistemic and emotional dismissals. But this isn't only an issue for cis-gender women. As we saw with Kalma, a phenomenon that's common for many trans and gender non-conforming folks, fear of being deadnamed and misgendered is enough to preclude them from even setting foot in a hospital or clinic.[8] All of these reactions are related to the problem of microaggressions.

Though the actions under consideration may seem 'micro' from the perspective of the health care providers, the harms suffered are not at all micro and can lead to people avoiding health care settings to the detriment of their health.

In one of the only two empirical studies of which we're aware that specifically focuses on microaggressions toward patients within medical contexts, the investigators conducted in-person interviews with 218 adult American Indians diagnosed with type 2 diabetes.[9] They found that greater than one third of participants self-reported having experienced microaggressions in interactions with health care providers, which correlated with self-reported history of heart attack, worse depressive symptoms, and prior-year hospitalization. Moreover, the

researchers claim that microaggressions, in addition to other kinds of discrimination faced by members of marginalized groups within medical contexts, can ultimately contribute to worse behavior; poorer physical, and mental health; decreased service utilization; and reduced treatment compliance.[10] Decreased service use and treatment compliance can in turn result in further disease complications and comorbidities.

This is a serious problem, one, we believe, that cannot be ignored.

Our conclusion is this: when a patient's health, well-being, and in many cases, their life is at stake, it's imperative to trust and to have a positive relationship with those in charge of your treatment and care. Experiencing microaggressions within medical contexts, however, can undermine this trust in health care professionals, leading to a variety of roadblocks for successful treatment, as well as serious psychological and existential pain for victims.

Thus, we must bring attention to the kinds of microaggressions that arise in medical contexts in order to try to diminish them as much as possible. Working to decrease microaggressions in medicine is especially important in light of the resurgent popularity of the concept of patient centered care. As we've shown, non-physical harms within the context of illness can be just as serious as physical harms, and can sometimes have an even greater impact on patients' long-term interactions with health care providers and health. To the extent that microaggressions result in various types of non-physical harm, medical practitioners need to take heed and work to reduce microaggressions.

Parts of this article were adapted from Freeman and Stewart "Microaggressions in Clinical Medicine." Kennedy Institute of Ethics Journal 28 (4), December 2018: 411-449.

Lauren Freeman *is an Associate Professor of Philosophy at the University of Louisville and a core member of the MA in Health Care Ethics.* **Heather Stewart** *is a PhD candidate at Western University (Canada). Together, they are writing a book called* <u>Microaggressions in Medicine</u> *which introduces their victim-based account of microaggressions, develops this account within the context of medicine, and offers health care providers practical tools to avoid committing microaggressions.*

[1] Lauren Freeman and Heather Stewart, "Microaggressions in Clinical Medicine," Kennedy Institute of Ethics Journal, 28, 4 (2018): 411-449. See also Lauren Freeman and Heather Stewart, "Epistemic Microaggressions and Epistemic Injustices in Clinical Medicine," Overcoming Epistemic Injustice: Social and Psychological Perspectives, ed. Benjamin R. Sherman and Stacey Goguen (London: Rowman & Littlefield, 2019).

[2] This conceptualization of microaggressions was developed primarily in the work of Derald Wing Sue, and especially his 2010 book. See Derald Wing Sue, Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation (Wiley, 2010). See also the work of his former student, Kevin Nadal, That's So Gay!: Microaggressions and the Lesbian, Gay, Bisexual and Transgender Community (Perspectives on Sexual Orientation and Gender Diversity (American Psychological Association, 2013).

[3] Ed Cara, "Hospital Apologizes for Ignoring Cancer Patient Who 'Googled' Her Symptoms." Medical Daily, 18 June 2015. Accessed December 27, 2015. https://www.medicaldaily.com/doctors-apologize-telling-19-year-old-cancer- patient-stop-googling-symptoms-admit-338986. See also Ranjana Srivastava, "Doctor Google Is Here to Stay—and Here to Help." The Guardian. 22 June 2015, https://www.theguardian.com/commentisfree/2015/ jun/22/bronte-doyne-cancer-google.

[4] Heather Stewart, "Bisexual Microaggressions in Medical Contexts," Bisexual Resource Center Blog, 23 March 2019, http://biresource.org/bisexual-microaggressions-in-medical-contexts/.

[5] See, for example Rebecca Kukla, Mass Hysteria: Medicine, Culture, and Mothers' Bodies (New York: Roman and Littlefield, 2005); Judy Foreman, A Nation in Pain: Healing Our Biggest Health Problem (Oxford: Oxford University Press, 2014); Lorraine Code, What Can She Know? Feminist Theory and the Construction of Knowledge (Ithaca: Cornell University Press, 1991); and Maya Dusenbery, "Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick" (New York: HarperOne, 2018).

[6] Cara, "Hospital Apologizes for Ignoring Cancer Patient Who 'Googled' Her Symptoms."

[7] Zena Sharman, The Remedy: Queer and Trans Voices on Health and Health Care. (Vancouver: Aresenal Pulp Press, 2017), 206, emphasis added.

[8] For a discussion of this problem see Lauren Freeman and Saray Ayala López, "Sex Categories in Medical Contexts: A Cautionary Tale." The Kennedy Institute of Ethics Journal 28, 3 (2018): 243–280. See also Lauren Freeman, "Micro Interactions, Macro Harms: Some Thoughts on Improving Health Care for Transgender and Gender Nonbinary Folks." International Journal of Feminist Approaches to Bioethics. 11, 2 (2018): 157–65.

[9] Melissa L Walls, John Gonzales, Tanya Gladney, and Emily Onello, "Unconscious Biases: Racial Microaggressions in American Indian Health Care," Journal of the American Board of Family Medicine 28 (2015): 231–239.

[10] Ibid., 233-237.

Microaggressions and Invisibility

by: Vicki Hines-Martin, Professor and Acting Assistant Dean, School Of Nursing Director, Community Outreach, HSC Office of Diversity and Inclusion

Many people have heard the phrase "death by a thousand cuts" which originates from western civilization's description of *lingchi* , a Chinese form of lingering death which served as punishment for those convicted of crimes. The convicted person was killed by small ongoing traumas to the body which accumulated over time and resulted in death. So what does this have to do with *microaggressions?*

Microaggressions can also be seen as "death by a thousand cuts" in that they are small traumas to one's dignity, self-esteem, hope and perceptions of being "other" over the course of a lifetime. There are many times when it is not the major traumas in life that kill, but rather what has been labeled as "creeping normalcy"—a way of interacting that has been incessant and cumulative, and ultimately can be devastating. They are subtle expressions of stigmata or put-downs which are brief and commonplace such as daily verbal, behavioral and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative slights and insults to the target person or group (Wang et al., 2011).

Microaggressions can also include incidents of exclusion or marginalization, more specifically, *invisibility* i.e., feeling ignored or overlooked owing to one's group membership (gender/ gender identity, race, ethnicity/ nationality, religion, disability, class and /or sexual orientation), and the distress caused by such experiences (Franklin & Boyd-Franklin, 2000). Exclusion or marginalization is frequently discussed in relation to entire groups but has significantly less discussion as to how it is expressed as a microaggression at the interpersonal level. However, invisibility occurs at the individual level when the target person's contributions are dismissed, discounted, devalued, minimized or compartmentalized because it is viewed as less valued or relevant to the dominant group. These acts cause anger and frustration, lowering subjective well-being and can result in microaggressive stress among the targeted group (Sohi & Singh, 2016; Sue, 2010).

Invisibility flourishes in environments that do not acknowledge that it exists but can also be unaddressed or inadequately addressed in settings that feel they are actively striving for inclusivity. In educational settings that are striving for inclusivity, individuals who are most likely to experience this microaggression are those who subsequently are the leading voices for change; they are the identified champions for sharing the vision and their roles are primarily tied to implementing that change. These are all very valuable endeavors.

The important measure of the outcomes of these actions for change is to what degree has that "invisibility" changed; not in terms of the organization's ability to point to the locus of their efforts ("here's where we do our diversity work") but in how those efforts have influenced those in power to address the invisibility ("I see you") and alter the environment in which those efforts exist. This cannot be done by compartmentalizing inclusion or relegating the task only to those who have been marginalized. Dismantling invisibility means reflecting inclusion in all aspects of the environment – levels of personnel, resources, innovations, perspectives and priorities.

I will believe invisibility is defeated in our setting when gender/ gender identity, race, ethnicity/ nationality, religion, disability, class and /or sexual orientation diversity is expected and reflected to a similar degree throughout the university as it is in *our diversity-focused initiatives*. That's the challenge vs. the "thousand cuts". Now it's your move…

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* Wang, J., Leu, J., & Shoda, Y. (2011).When the seemingly innocuous "stings": racial microaggressions and their emotional consequences. Pers. Soc. Psychol. Bull. 37, 1666–1678. doi: 10.1177/0146167211416130

Excuse Me Sir/Ma'am, May I Misgender You?

by: Bláz Bush, Director, LGBT Center, Health Sciences Center

You may be thinking, "Well the LGBTQ population is only estimated at around 10% of the population, why do I need to change something I consider respectful for a small group." The Louisville LGBT population is 4.5% which makes it the 11th city in the US for LGBTQ population size. This means 5 out of every 100 people seen in a practice are part of the LGBTQ community. I promise you, to a community striving for inclusion and affirming care, it makes a HUGE difference. For the LGBTQ community, this small change matters. Also, once you know someone's pronouns, (because you asked, of course!) you can confirm if they would like or are comfortable for you to use these titles if it is important to your, or their, beliefs.

There isn't time to go into all of the micro-aggressions LGBTQ folks face when seeking health care, however, in *That's So Gay: Microaggressions and the Lesbian, Gay, Bisexual and Transgender Community* (2013) Kevin L. Nadal describes 9 categories of microaggressions directed at LGB people and eleven categories for people who Identify as TGNB (Transgender, Non-Binary) which are the following:

1. Use of heterosexist terminology
2. Endorsement of heteronormative or gender normative culture and behaviors
3. Assumption of universal LGB experience
4. Exoticization
5. Discomfort with or disapproval of LGB experience
6. Assumption of sexual pathology, deviance, or abnormality
7. Denial of the reality of heterosexism
8. Physical threat or harassment,
9. Environmental microaggressions (Nadal 2013, 54-71).

Additionally, Nadal identifies two further categories for microaggressions toward people who identify as TGNB:

10. Denial of bodily privacy and
11. Systemic microaggressions (Nadal 2013, 85-99).

If this is a topic important to you, I highly recommend the additional reading of the two articles mentioned.

Dean, M.A., Victor, E. & Guidry-Grimes, L. Bioethical Inquiry (2016) 13: 557. https://doi.org/10.1007/s11673-016-9738-9

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Personally Mediated Racism in Action: An Escalation of Segregation-era Scare Tactics

by: Xian R. Brooks, MPH, Program Coordinator, University of Louisville HSC Office of Diversity and Inclusion

Down a two-lane country road, past cows, horses, maybe a random barking dog and cozy homes, you take a left down a smaller road, then you turn right onto an even smaller road. You travel up a slight incline. It's a little bumpy, but there nestled in the Smokey Mountains, east of Knoxville, is The Highlander Research and Education Center. For eighty-seven years, the Highlander Research and Education Center has been the quintessential folk and popular education school for community leaders across the

Anne Braden and Ella Baker at Highlander
Photo Credit: Unknown
Photo From: Zinn Education Project

world. A place where folks can gather to develop, hone, and share skills to take back home and get to work. Singing and dancing are common forms of communication. Art. Oral history. Home. Much like the role of the elder matriarch of a family, Highlander is the keeper of histories, the holder of narratives, and the healer of traumas.

On March 29, 2019, the main administrative building of the Highlander Center caught fire. Though investigations are still trying to determine if the fire was intentionally set, Jefferson County Sherriff confirmed that a white power symbol was found graffitied on the property. No one was hurt. This was not the first time that Highlander has experienced backlash from individuals and institutions opposed to its mission and vision. All throughout the 1950s and 1960s, Highlander served as the foundation for the development of civil rights organizations like the Student Nonviolent Coordinating Committee, and was visited by Civil Rights icons, such as Rosa Parks and Ella Baker. Highlander was targeted for allegedly being a "communist training school", putting them on the FBI radar, which resulted in the revocation of the Center's charter and the federal misappropriation of their

land and property in 1961 (Highlander Research and Education Center, 2019).

Personally mediated racism is what most people think of when they hear the word "racism". It can look a variety of ways, including, but not limited to lack of respect (poor or no services in communities), dehumanization (state sanctioned police violence), or devaluation (surprise at competence) (Jones, C., 2000). The Highlander fire is one of the many recent incidents of scare tactics reminiscent of segregation-era personally mediated acts of racism. Surely, we cannot forget the October 24th, 2018 shooting at the Jeffersontown Kroger that took the lives of two community elders, Maurice Stallard (69) and Vickie Lee Jones (67). While drafting this article, three historically Black churches in one Louisiana parish were burned down with evidence pointing to "suspicious elements", and are believed to have been intentionally set (Fausset, R., 2019).

In 2017, the number of hate crimes reported in the US increased by 17%. Anti-Latinx hate crimes increased by more than 24%, anti- American Indian and Alaskan Native by almost 63%, and hate crimes targeting African Americans accounted for 28% of all reported hate crimes. Anti-religious bias-based hate crimes increased by 25%, with a large proportion of the increase being due to the 37% increase in anti-Jewish based hate crimes (FBI, 2018). Muslim identified individuals accounted for 18.7% of religious bias-

es based crimes. This is a six per-cent drop from 2016, but it is posit-ed that anti-Muslim based hate crimes are underreported and there are discrepancies between state and federal level hate crime data (FBI, 2018; Arab American In-stitute Foundation, 2018).

Kentucky has seen its share of increased bias-based vandalism and hate crimes. The 2017 FBI re-port indicated a 79% increase in reported hate crime incidents in just one year; 2016-2017 saw al-most five times the national in-crease (FBI, 2018). According to Kentucky State Police, the majority of reported hate crimes in Ken-tucky are racially motivated, fol-lowed by religion and sexual orien-tation (Mills, A., 2018).

So, what do we do? What can we do?

·NAME IT
-THAT'S NOT OK

· CLAIM IT
-I'M NOT COMFORTABLE WITH THAT

- STOP IT
-PLEASE DON'T USE SEXIST LANGUAGE
-PLEASE DON'T MAKE RACIST COMMENTS*

• RECOGNIZE AND UNDERSTAND YOUR OWN PRIVILEGE AND BIAS

• VALIDATE LIVED EXPERIENCES OF MARGINALIZED FOLKS; PEOPLE OF COLOR, LGBTQ+, WOMEN, FEMME IDENTIFIED FOLKS, FOLKS WITH DISABILITIES ETC.

• CHALLENGE "COLOR BLIND" IDEOLOGY

• CALL OUT RACIST, SEXIST, HOMOPHOBIC, TRANSPHOBIC OR OTHER INAPPROPRIATE "JOKES"

• EXAMINE AND CHALLENGE YOUR COMPANY OR INSTITUTION'S BARRIERS TO INCLUSION AND HIRING PRACTICES

• EMBRACE AN INTERSECTIONAL LENS FOR ALL ASPECTS OF YOUR LIFE

* Provided that it feels safe

Resources

For more information about the Highlander Research and Education Center visit highlandercenter.org

And check out The Roots of Activism: Kentucky and Radical Southern Organizing display at Ekstrom Library until April 26, 2019.

For more information on the practice of intersectionality and Kimberly Crenshaw https://www.aaup.org/article/what-intersectionality-and-why-it-important#.XLX8rehKiUk

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Are You a Perpetrator of Microaggressions? How Do You Know if You Are?

by: Karen W. Krigger, MD, Med, FAAFM, AAHIVM(S), Health Sciences Center Office of Diversity and Inclusion Director of Health Equity, Professor of Family and Geriatric Medicine

Microaggressions exist in a context of privilege vs marginalized populations. Often subtle and reflexive, they express forms of discrimination based on minority status, sexism, ablesism discriminations in favor of able-bodied people), and homophobia. A global definition of microaggressions I find acceptable is "commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate hostile derogatory, or negative insults to a target population or group" as elucidated by Dr. Derald Wing Sue PhD. Professor of Psychology and Education at Columbia University. The concept of microaggressions may be new to some of us.To begin, microaggressions can be placed in four different categories.

"Microinsults" are often unconscious behaviors, remarks, or environmental cues that communicate rudeness or insensitivity. They can be visual or demeaning verbal comments intended to be complements that remind marginalized individuals they are not respected nor expected to perform well. Examples – "You do not look gay!" "You speak very well". Another ex-

ample would be taking attendance at a meeting, calling everyone in the room by name except the only marginalized person in the room. Verbalizing the names of all the meeting participants fosters group cohesiveness and name recognition. Not verbalizing everyone's name implies that person will not be a productive member or they are not important enough to be recognized. In medical offices, calling an elderly person by her first name can be viewed as a microaggression. Some believe such an action is meant to provide comfort and familiarity to the elderly patient. In the south, the action of a stranger calling an elderly person by their first name can be interpreted as disrespect for the years they have lived. Its effect on the person may be recorded as an increase in their blood pressure. In that patients often see medical staff as an extension of their provider, patients may transfer negative feelings of perceived disrespect to the provider affecting the doctor / patient rapport.

Microinvalidations are often unconscious, as well, serving to directly erase or dismiss lived experience of marginalized groups. Such an example would be not acknowledging the needs for public events that celebrate marginalized communities. Not supporting actions eliciting past historical events. "Racism is a thing of the past. Why do we need to spend time, money, resources, acknowledgement, etc. on that?" In meetings, a marginalized member makes a suggestion or comment that is not internalized by the group, but minutes later a member of the privileged population makes the same comment and the same comment is acknowledged as noteworthy. Marginalized individuals may be loath to ask, "What did you think I said a minute ago". The cumulative effects of a lifetime of these experiences communicates non inclusiveness and worth to the marginalized person fostering non-participatory behaviors.

Microassaults are basically old-fashioned bigotry. They are often deliberate and reflect biased beliefs held by individuals who express them in covert or overt ways. This type of microaggression only occurs when the offender feels safe expressing prejudicial attitudes either because of anonymity or believing they are in the company of others with the same viewpoints. It is important to identify the places and times these actions take place as it reflects a society permissive of certain kinds of bigotry. In a large group setting of impressionable learners, this accepta

bility of the microassaultive actions by the group leaders, teachers, or faculty fosters the permeation of this type of thinking as acceptable, professional behavior. It should be noted, when such covert actions are deemed socially inacceptable, it does not necessarily mean they dissipate. They may become convert in nature. A prevalent example of microassaults include "these ____ people are always late". I have heard this applied to multiple populations in this country. The marginalized population receiving this comment is generally regionally dependent i.e. African – Americans in the south, American Indians in the south west, and Hispanics in other parts of the country, etc. The fact is certain cultures value time and its commitments differently as anyone traveling outside this country to non – European territories can attest. It is not as important to be "on time" as to complete the focus of one's attention in that moment before moving on in life events, a concept explained to me by a group of American Indians when I announced our conference schedule would follow a set agenda beginning and ending on time!

Environmental microaggressions are communicated individually, institutionally, or societally to marginalized groups. Examples of environmental microaggressions would be school desks not large enough to accommodate larger students, exam tables that cannot be height adjusted for patients with disabilities, health insurance communications sent only in English and Spanish without recourse to other languages. Other examples include seating marginalized populations near the kitchen areas in restaurants, or store security personnel only following marginalized populations in stores. A few years ago, the young fathers in our congregation expressed a need to have a place to take their young children during church service when the children were in need of alternative spaces. All the cribs, toys, and children calming accruements were in the women's bathroom suite which had private restroom facilities. The women's suite name was changed to "family" to allow the young fathers to participate in child care responsibilities. The privacy of the women's rest room was preserved in the change. The men no longer felt excluded.
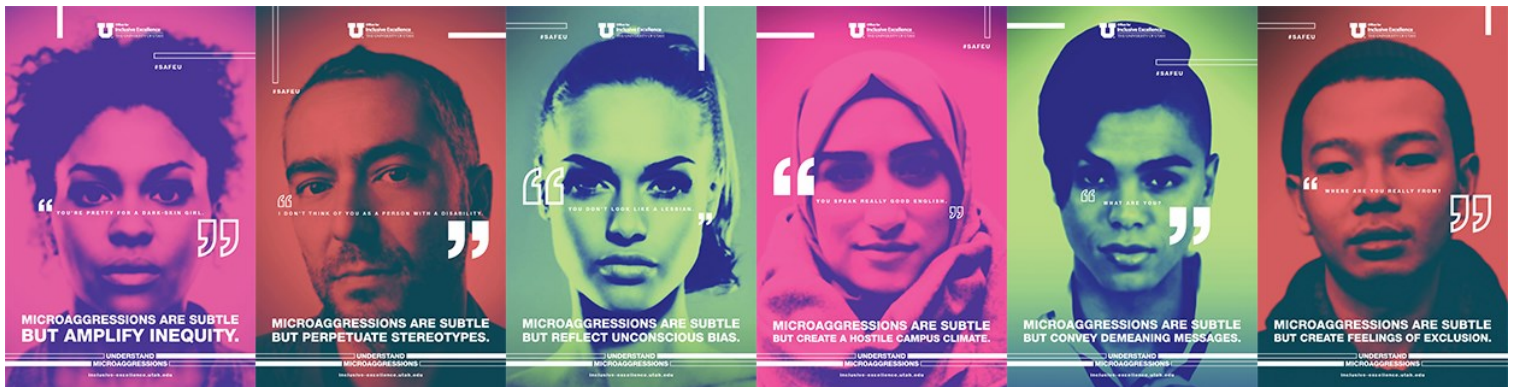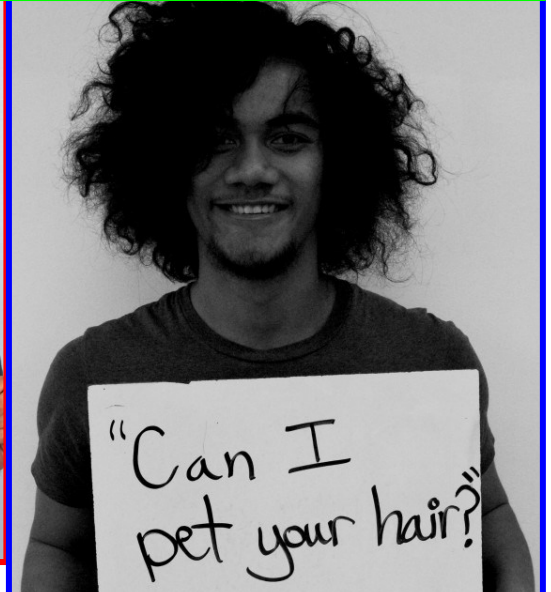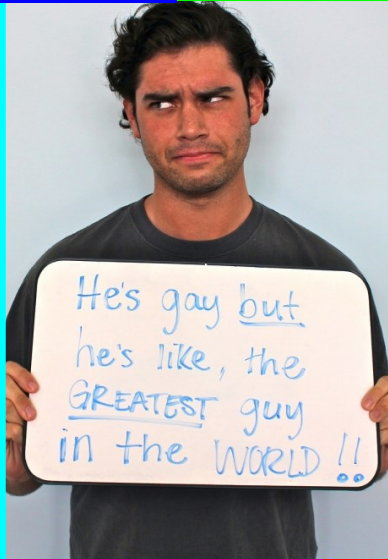

Source: "But I Didn't Mean it Like That!", University of Utah Continuum, Inclusive-Excellence.utah.edu
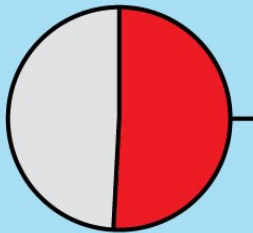
Today's Lesson:

Microaggressions

"I DON'T SEE RACE. I'M A GOOD PERSON.

Micro-Aggressions

"You're going to stay home with the baby? Are you really going to let your wife wear the pants in the relationship?"

"Do you know where I can buy marijuana?"

"YOU were born in Canada?"

"You have a mental disability? You seem perfectly normal to me."

"Are you a man or a woman?"

"You Natives don't have to work, doesn't the government give you everything for free?"

"You speak really good English for an immigrant."

"Why haven't you found a husband yet?"

"I DON'T SEE COLOR."

"But you ALL look alike."

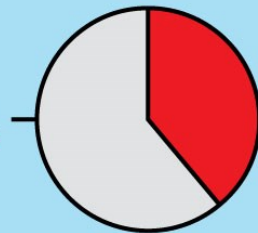He's gay but he's like, the GREATEST guy in the WORLD !!

"Can I pet your hair?"

How Students of Colors Experienced Microaggresions in College

51% of students experienced some type of stereotyping in the classroom

39% felt uncomfortable on campus because of their race

Information from University of Illinois at Urbana-Champaign

So when are you gonna REALLY transition?

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Microaggressions: Educational Resources

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