

Small Group Session Racial Bias in Medicine

Facilitator's Guide

Introduction and Ground Rules (10 minutes)

- 1) Listen actively
- 2) Communicate in a nonjudgmental fashion
- 3) Do not be afraid to respectfully challenge each other by asking questions, but refrain from personal attacks
- 4) Use "I" statements—speak from your own experience
- 5) Maintain confidentiality
- 6) Reveal only what you feel comfortable revealing about yourself
- 7) There is no one "right" answer
- 8) *The goal is not to agree; it is to gain a deeper understanding*

Facilitator's notes:

Read the ground rules and ask if clarification is needed. Ask if anyone would like to add items. Elicit from the group members the steps they want to take if the ground rules are violated. Each participant can remind the group of the ground rules during the session.

Each case in the facilitator's guide includes notes, which may help you to guide the students in discussion when they seem reluctant to speak or when they are stuck in the discourse. These notes will provide you with context, but it is important to avoid dominating the conversation. Encourage the students to discourse with one another, rather than responding directly to you, the facilitator. When questions are directed to you specifically, if appropriate, reflect the questions back to the group to come up with suggestions. To keep the conversation moving, ask questions similar to: "Did anyone have a similar or different reaction?" or "How would you respond to that comment?"

Review of frameworks (5-10 minutes)

Review the frameworks below with the students. Throughout discussion of the cases, it can be helpful to frequently come back to the CHARGE² and INTERRUPT frameworks to help the students navigate the discussion.

CHARGE²

- C-** Change your context: is there another perspective that is possible?
- H-** Honesty: Be honest with yourself, acknowledge and be aware
- A-** Avoid blaming yourself; know that you can do something about it
- R-** Realize when you need to slow down
- G-** Get to know people you perceive as different from you
- E-** Engage: Remember why you are doing this
- E-** Empower your patients and peers

INTERRUPT

I- Inquire: Encourage elaboration, leverage curiosity. "I'm curious, what makes you think that?"

N- Non-threatening: Convey the message with respect. Separate the person from the action or behavior. "Some may consider that statement to be offensive." Communicate preferences rather than demands. "It would be helpful to me if..."

T- Take responsibility: If you need to reconsider a statement/action, acknowledge and apologize, if necessary. Address micro-aggressions and revisit them if they were initially unaddressed. "Let's go back..."

E- Empower: Ask questions that will make a difference. "What could you/we do differently?"

R- Reframe: "Have you ever thought about it like this?"

R- Redirect: Helpful when an individual is put on the spot to speak for their identity group. "Let's shift the conversation..."

U- Use impact questions: "What would happen if you considered the impact on..."

P- Paraphrase: Making what is invisible (unconscious bias), visible. "It sounds like you think..."

T- Teach by using "I" phrases: Speak from your own experience. "I felt x when y happened, and it impacted me because..."

Case 1 (10-15 minutes)

On an OB ward at a private hospital, the triage area is often filled with patients without insurance who are known as “service patients.” Many of these patients are immigrants from Haiti. A student on the OB-Gyn clerkship frequently observes nurses and other health care providers disdainfully remarking that the patients come to this hospital “because they heard about the sandwiches and Nintendo,” and “want a private room to deliver their babies at the hospital’s expense.” On the first day of the clerkship, the residents recommend that students try to be present for the examinations and deliveries of service patients since students could take a more active role in these cases, including participating in the deliveries to “catch the baby.” Students are excluded from the care of private, insured patients.

One evening, a black couple originally from West Africa come in after the woman noted vaginal bleeding at 6 weeks gestation. The resident goes into the room to do an ultrasound which shows a miscarriage. She delivers the news to the couple. When she exits the room, she looks at the student and says, “I feel so bad for the family. They are good people: they have insurance.”

Prompting questions:

- 1) What do you think the resident means by this remark?
- 2) What set of assumptions motivated the resident’s response?
- 3) How do the implicit and overt biases in the healthcare workers in this ward influence the quality of care for patients?
- 4) How could these assumptions and biases be challenged/changed:
 - a. At the level of resident-student: What would you do in this situation?
 - b. At the level of the clerkship: What could a clerkship director do?
 - c. At the level of hospital culture: What systemic-level cultural changes might be helpful to shift the cultural norms in this institution?

Facilitator’s notes:

Case themes: Toxic environment shaping healthcare worker’s reactions and treatment of patients. Assumptions that immigrants or people of color or those without insurance are less valuable to society and/or less deserving of high quality care.

It is important to consider what the resident means by her remark. Does she mean to say that patients without insurance are not “good people” or that they may be less deserving of good medical outcomes? Why does she feel compelled to explain that the patient and her husband, who are black but different from many of the other patients with respect to country of origin and insurance status, are “good people”? The context at this particular hospital, where she has frequently overheard comments disparaging Haitian and other patients without insurance, likely influenced her remark. Students may acknowledge that stress and distress can sometimes cause errors in judgment that can lead these types of comments, even when someone has good intentions. The resident may mean the remark as an expression of sympathy or compassion. Her own distress as a trainee having to deliver bad news to a young couple may also have an influence on her ability to appropriately express this compassion.

Students may discuss their commitment to ensure that all patients, regardless of insurance status or race/ethnicity and country of origin should receive the same level of care. They may also recognize that the current healthcare system is not set up in a way that facilitates this, but rather can perpetuate

inequalities. Is the care structure at this hospital necessarily inequitable? Is the involvement of medical students in the care of the “service” patients detrimental to their care? Students may bring up the value added when students and teaching are a part of the healthcare environment. They may also discuss how concerns about malpractice in a high-risk specialty may also contribute to the current structure. However, it is important to note that this care structure can lead to inferior care when healthcare workers view the immigrant or uninsured patients as less deserving, flawed, or greedy. These underlying themes can emerge in decisions that are made about patient care and in the attention given to patient concerns and chief complaints, and can even emerge as unconscious bias among healthcare workers in this environment who do not explicitly ascribe to these beliefs.

In addressing this type of situation in the moment, the I-Inquire of the INTERRUPT framework could be helpful: “I’m curious, what makes you say that?” P-Paraphrase may also help the resident identify that her comment is potentially charged with assumptions about uninsured patients. “It sounds like you think that patients without insurance are not good people.” Or “Some might interpret that comment as disparaging against patients without insurance” (INTERRUPT N- Non-threatening). If appropriate, the clerkship director could discuss the atmosphere with the residency director and the faculty at the site. At the same time, a cultural shift at the institution itself may be needed, and this will require buy-in from leadership at the hospital, to provide training for all staff around cultural humility and how bias can detrimentally affect care.

Importantly, many students may have experienced or heard similar remarks either in their experience with the healthcare system or in their personal lives. Many people in our society believe that healthcare is a privilege and not a right. Students can be encouraged to discuss this and to think of ways that they can avoid being influenced by similar environments where resentment surfaces in the care of uninsured patients (e.g. CHARGE²).

Case 2 (10-15 minutes)

At a community preceptorship at a suburban, outpatient internal medicine office, a student observes the clinical encounter of a white, middle-aged man who has come in for a check-up on his diabetes medication. At one point, the patient turns to the student and strikes up conversation while the preceptor is writing out prescriptions. He states to the student, who is a white woman, "It's great to see someone like you here studying to be a doctor." When the student asks what is meant by the patient's statement, he replies, "You know, not one of those Indian doctors." He proceeds to tell a story about a recent hospitalization where he was cared for by an Indian doctor, who "could barely speak English" and "kept messing everything up. The nurse had to come in and fix everything she did!" The preceptor responds "Well, at least you're feeling better now." After completing the visit, the student and preceptor move on to the next room, and the preceptor makes no mention of the patient's comments.

Prompting questions:

- 1) What is your first reaction to this scenario? What would you do/say, if anything?
- 2) Does the race/ethnicity of your physician matter?
- 3) Do you believe the preceptor had a responsibility to address the patient's remarks? If so, how might he do this? Should he do it in front of the patient or as a debriefing with the student after the encounter?
- 4) Is it our responsibility to change or address the biases our patients may have? Why or why not?

Facilitator's notes:

Case themes: Patient expressing bias against a healthcare worker based on race and country of origin. Physician's moral obligation to address/correct patients' biases.

Students will immediately sense the discomfort and difficult position the student in the scenario is facing. Some may express shock, dismay, and anger at the patient's beliefs. There are many underlying assumptions and beliefs that can make these statements unsettling, including the patient's belief that a physician's race can determine their aptitude as a physician, and that white people are better positioned to be effective physicians. It is important to note that these types of scenarios may be increasing in frequency, and that students and physicians of color may have to face these types of comments-- and perhaps some scenarios that are even more explicitly racist-- from patients in the course of their careers.

Students will likely have varying opinions about whether they should say something to the patient in this scenario, and it is important to recognize that there is no one correct answer. They may acknowledge that saying something may alienate the patient or put him on the defensive. As a visiting student in a community practice, this risks altering the patient-physician relationship from the point of view of the preceptor. When addressed, using the second T (Teach by using "I" phrases) of the INTERRUPT tool may be helpful. "I'm sorry that that was your experience. My experience has been completely different; I know so many wonderful Indian medical students and physicians." This response both acknowledges that the patient perceived that he had a bad experience with his care, but also validates that this experience does not represent the norm, and suggests that she hopes it will not cloud his perception of his future care.

Interestingly, some studies show that the race/ethnicity of your doctor can matter, especially when the race/ethnicity is congruent. In particular, racial/ethnic minority patients report increased comfort levels when they are matched with physicians of the same race/ethnicity or when they speak the same language. At the same time, studies also show that anxiety around racial mismatch between patient and physician can be minimized with physician training in perspective taking, empathy, and cultural humility—topics that we explore further in this course. Practically, it is neither possible nor advisable to ensure race/ethnicity congruence for patient/physician pairs. We want to ensure that everyone in the workforce is valued and supported. Inclusion and diversity in the workforce strengthens the workforce. Many hospitals have adopted policies that state that they have full confidence in all of their employees and requests for changes exclusively based on race/ethnicity will not be permitted. However, when patient's views are explicit, threatening, or the result of severe psychiatric disease, it may be most appropriate for a provider to step away from the care of the patient for the sake of safety and identify an alternate provider.

In this case, the preceptor makes no effort to address the patient's bias. There are many reasons why he may decide not to pursue it. Students may discuss that the preceptor does not feel comfortable, he does not want to alienate the patient, he has never had training on how to address this type of situation, or he may hold the same views. By not debriefing with the student afterward, we cannot be sure of his motivations. This is why debriefing in this situation, even if you do not feel comfortable or are taken off-guard in the moment, can be helpful after the fact (INTERRUPT T for Take responsibility). We should strive to create a safe place where we can discuss the matter without judgment. The patient-physician dynamic must be preserved in this case, but so should the team dynamic. A brief 1-2 minute discussion and check-in with the student can help to explore the reactions to the patient's expressed bias and discuss ways to address similar situations in the future.

Lastly, students will debate whether we have a responsibility to be moral leaders and to argue for a change in patients' explicit or expressed biases. Again, there is no one right answer, and each of us will find our own style in addressing this. The circumstances may also dictate whether addressing bias would be safe or if the patient would be receptive to discussion.

Case 3 (15-20 minutes)

During a surgery clerkship in the middle of the night, a student accompanies the surgical fellow to evaluate a patient. The patient is a 16 year-old black male with a stab wound to the abdomen. Upon initial examination, the wound appears superficial, the patient's vital signs are normal, and further work-up, including a CT scan, is not concerning for any abdominal bleeding or bowel perforation. The fellow, who is visiting from a highly-respected outside institution, has on many occasions described her enthusiasm about this visiting rotation to the student, saying she is "excited to get the crazy stuff" on the trauma service resulting from violent crime in Newark. She is hopeful she will get many more opportunities to develop her surgical skills. In this case, she elects to do an exploratory laparotomy (an invasive surgery). When the emergency medicine resident challenges this decision, she snaps at him in front of the student. The student is also not sure of the indication for the surgery.

Prompting questions:

- 1) What are the assumptions/beliefs around race that may have motivated the fellow's medical decision-making? Do you think the scenario could be different if it involved a 16 year-old white male?
- 2) How can race shift the power dynamic between patients and healthcare personnel?
- 3) Would you say anything to the fellow? Why or why not? If so, what would you say?
- 4) To whom can the student turn to debrief or for support in case of feeling dismayed or traumatized by this situation?

Facilitator's notes:

Case themes: Racial factors in the patient-physician power imbalance, exploitation for the sake of personal gain, navigating the medical hierarchy in a high pressure situation

It is important to note that based on the limited information provided here, it appears the fellow is not following trauma protocol and proposes to perform a procedure that is unnecessary and puts the patient at great risk for harm. In this case, students may discuss that the fellow's decision making could be affected by her underlying assumption that black patients or patients who are victims of violence are of lower value to society. Her eagerness to hone her surgical skills in a trauma center that cares for many victims of violent crime as a means to enhance her skills is inherently de-humanizing, and highlights the power imbalance for this young person of color who may be perceived as having little recourse to challenge this decision or advocate for repercussions for flawed medical decision-making on the part of the medical team. Students may argue that whether similar assumptions would be made of patients of different races may in part depend on other factors that could lead providers to stereotype—such as psychiatric disease, substance use disorder, and signs that the patient is a part of gang culture. At the same time, the element of race in this scenario further exacerbates the power imbalance, and can make it easier for healthcare providers to de-humanize, de-value and "other" patients, given internalized messages about race in our society (unconscious bias).

This is an extremely difficult position for the student to face, particularly in light of witnessed interaction between the fellow and the resident. Students may discuss that the hierarchy in patient care can make it especially difficult to navigate this situation. They must worry about the defensiveness and backlash of the fellow, as well as their grade for the clerkship. Again, the INTERRUPT framework may be helpful here,

but it's entirely possible that intervention may not have an effect on the fellow, since she seems committed to her plan. Elements of INTERRUPT that can be helpful include N-non-threatening, I-inquiry ("I'm curious, what is the main indication for surgery for this particular patient?"), U-use impact questions ("What would be the impact on this patient if the surgery turns out to be unnecessary?"), and T-teach using "I" phrases ("I am feeling very uncertain about this situation. I am worried that surgery may not be the best option, and this makes me uncomfortable. Could we slow down for a minute and discuss this with the attending?") If this is not possible, then discussing concerns with the EM resident or EM attending may be appropriate as well.

In the end, if the fellow proceeds with her plan, this can leave a lasting emotional effect on the care team. It is appropriate for the student to discuss concerns with the attending, the clerkship director, and/or student affairs. Other resources include the Ombudsperson, who is a designated, confidential resource for students and house staff seeking solutions to problems faced in the academic setting that can remain completely anonymous if desired; as well as the hospital Chaplain, who can provide emotional support to staff as well as patients/families. Additionally, any member of the care team can submit an event report to the hospital to report medical error. When never-event like this occurs, it can be very important to debrief and discuss emotional reactions and future directions, so taking advantage of these resources can be of critical importance for the care team's wellness.

Case 4 (10-15 minutes)

Two medical students, a black woman and a white woman, are on their first day of an OB-Gyn outpatient clinic rotation. The preceptor has not yet arrived, so the nurse asks both students to get a history of a patient waiting in the exam room. As the students are completing the history with the patient, the attending walks in and addresses the black student, assuming she is the patient, “So, when did you last see your obstetrician?”

Prompting questions:

- 1) How might each student be feeling/thinking in this situation?
- 2) Do you worry that you may be mistaken for someone other than a doctor or medical student, even when in your role? What would you say in this situation if the assumption were made about you? If it were made about a fellow student?
- 3) Reflect on your own experience taking the IAT. Based on your results, can you imagine making an assumption about someone based on one of the categories tested in the IAT? What would you do if you were the person who mistook the student for a patient in this scenario?

Facilitator’s notes:

Case themes: Unconscious bias manifesting as a microaggression in the culture of medicine, power shifts in the healthcare team

Students may discuss that the attending has no ill intention, and that because she was running late she is less observant and relying more on her automatic thought processes. However, the effect can be profound, particularly on the black student. She is in effect “demoted” from her position in the room as the doctor-in-training, leading to a power shift. She must try to process and confront the unconscious bias that influenced this mistake, and because of stereotype threat, this can be paralyzing. This can be very difficult for the students to have to process and react in the moment—especially in light of the hierarchy in the room. Students may discuss that the white student may feel confused, and even guilty—her status is recognized and understood to be the healthcare worker in the room, which can make her feel exposed for her privilege of having a positive assumption made about her.

This is a scenario that can occur frequently in the healthcare setting, particularly for healthcare workers of racial/ethnic minority groups and women. Unconscious bias is at work here; our brains are hardwired to associate certain types of people with the role of physician—and we can even be biased against our own groups. This is further exacerbated by the fact that racial/ethnic minority groups are underrepresented in the physician workforce. It can be important avoid blaming (A-CHARGE²) for the workings of our brains that make automatic assumptions. At the same time, it is critical to try to address the incident, if not in the moment (since the patient is present in the room), then after the fact, so that everyone in the room can learn from it. Multiple elements of the INTERRUPT toolkit could be helpful: N-non-threatening, T-teach by using “I” phrases, and T-take responsibility to address the issue.

It is important to recognize that we will all find ourselves in a similar position of having made an incorrect assumption about a co-worker, a patient, or a patient’s family member—especially given the fast-paced and high-stakes atmosphere in medicine. Each of the elements of CHARGE² are relevant here, but in particular R-realize when you need to slow down, and E-empower yourself and your colleagues. Had the attending taken the time to fully evaluate the scene in the room and to go through proper

introductions at the beginning of the encounter, this may not have occurred. For INTERRUPT, T-take responsibility means owning up to your bias and assumptions and apologizing for the error.

Students may discuss and feel disconcerted about the fact that the information of whether the black student is wearing a white coat is not provided in this scenario. They may also discuss that sometimes social cues around race, gender, or other factors may be stronger than cues related to dress. Students of color may also note that they are more likely to be stopped by security at the hospital entrance, more likely to be judged by their presentation or dress, and more likely to be mistaken for another role even when dressed in white coats. Again, taking the time to slow down can be time saving in the end when situations like these are avoided, and can help to avoid power shifts in the healthcare team.

Importantly, programs that support diversity in medicine are critical to creating and maintaining inclusive and supportive work environments. Minority representation in medicine plays a vital role in changing the context (C- and G- of CHARGE²), and in enhancing the quality of care that we provide to diverse patient populations through teamwork and research.

Case 5 (15-20 minutes)

A 9 year-old black female presents to the emergency room from home with complications from an intracranial infection (subdural empyema). Prior to admission, her intravenous (PICC) line had fallen out. She has had several recent admissions, and her parents have repeatedly expressed anger and distrust with the healthcare team. A student on the admitting pediatrics team repeatedly witnesses nurses in the emergency department and residents on the neurosurgery and pediatric team refer to the patient and her family as “annoying,” “crazy” and “non-compliant.” At turn-over report the next day on the pediatric ward, one of the residents states, “They must be so stupid to pull the PICC line out. Mom and Dad are so negligent.” Another replies, “Why don’t they just leave. We shouldn’t even admit her anymore.” The student notes that healthcare workers making these comments are from a several different races and backgrounds.

Prompting questions:

- 1) Why do you think the healthcare professionals are reacting this way? Why are these types of comments accepted and shared by healthcare providers across specialties, responsibilities, and backgrounds?
- 2) Is the patient harmed by these comments and attitudes, even if she and her family do not overhear them? Why or why not?
- 3) What can the student say to the family to try to elicit their perspective? Why is this perspective important and how can it help the student and the healthcare team better understand the effects of the team’s comments?
- 4) Should the student discuss this incident with clerkship director or the dean of student affairs (or both)? Why or why not?

Facilitator’s notes:

Case themes: Othering phenomenon, high stress healthcare environment, importance of exploring the patient/family perspective

Students may discuss that it can be emotionally taxing to care for a patient so young with a potentially devastating neurologic injury. It can also be challenging to care for a patient and family who express a deep frustration and mistrust with healthcare. The extra effort and distress can be overwhelming, especially if the team is feeling overworked or fatigued. The healthcare workers in this scenario may have few outlets to cope with this frustration and distress, and may be using these comments to both relieve stress and to unite around a common sentiment, which further exacerbates the “us vs them” or “othering” phenomenon at play in this scenario. Race may also be a contributor, since it is easier to “other” and make assumptions based on many social and cultural factors—including race/ethnicity, language, cultural heritage, LGBTQ status, religion, geographic origin (urban, rural, suburban), and education, among others.

The patient is harmed by these comments; they re-enforce bias and can lead to flawed medical decision-making (“we should not even admit her...”). This bias can also cause a further deterioration of communication between the team and the family. To help the team recognize this, many elements of INTERRUPT could be helpful (E-Empower, R-Reframe, U-Use impact questions, P-Paraphrase). In this case, it appears that not only is the team biased against the patient and family, but that the family also

harbors a strong negative bias against the healthcare team and the system at large. This bias is severely compromising the ability of the healthcare team to effectively communicate with the family and to provide the best possible care for the patient. We cannot be sure about the origins of the distrust and anger, and making assumptions about these motivations can lead to further miscommunication. The best way to find out is to ask. As a medical student, you will find that you have more time to care for each individual patient—and this makes your role critical to the medical team. By taking the time to ask the family about their concerns, their priorities, and their prior experiences with healthcare, the family may find that they are being heard for the first time. By asking them about their distrust and validating their reactions and feelings, you may establish trust where there was none before. And by finding out how they perceive their loved one's illness, their hopes and expectations, and their understanding of the disease process, you may help to clarify misconceptions and miscommunications and empower them to approach communication with the team in a more effective manner (E-Empower "When you feel angry about a situation, what could you do differently to get people to understand your point of view?" U-Use impact questions "What do you think the impact of your words on the nurse is when you criticize her work?"). Remember that we are all human—and as a student you can help to put a human face on the healthcare system. You can also begin to develop skills that will help you be a more effective communicator and a more equitable provider as you progress through your training and take on more responsibilities in a high-stress work environment.

In this case, it may be helpful to discuss this scenario with the same resources we discussed prior—the clerkship director, Student Affairs, the chaplain. There are also mechanisms to provide feedback anonymously on the clerkship evaluation forms. By presenting this issue to a higher authority, such as your clerkship director or student affairs committee, you are opening the door to the possibility of positive change in this working environment. Most institutions welcome this feedback and medical schools are constantly looking for ways to improve the learning environment during the clerkships.

Lastly, a focus on wellness for the healthcare teams is warranted. Often, despite our best intentions, our automatic thinking processes take over when we're rushed, overwhelmed, fatigued, and forced to take shortcuts. As a medical student, you will begin to see your role in calling out ethical injustices in medicine since you may be the least fatigued person on the team. In this scenario, the caustic comments of these healthcare workers may be a symptom of the underlying problem of burnout. Students may benefit from brainstorming positive ways to deal with stress and optimize wellness (e.g. work-life balance, healthcare workers appreciation, retreats).

Wrapping up (10 minutes):

After the case discussions, elicit from the students 4-5 take-home points. Possible take-home points include:

- 1) You will see racism and racial bias (among other biases) in medicine—in patients, yourselves, colleagues, and systems.*
- 2) Race is a structural barrier to health shaped by institutional, personally-medicated, and internalized racism.*
- 3) Challenge your assumptions. Check in with yourself before, during, and after these types of encounters to process and learn from them. (CHARGE²)*

- 4) *Recognize that we all have bias, and we will ALL take unintentional missteps. Acknowledging these biases, addressing them directly and respectfully, and maintaining an open dialogue are key to transforming the culture of medicine. (INTERRUPT)*
- 5) *Understanding the patient's perspective is an important tool for combatting unconscious bias/assumptions, for enhancing communication, and for providing equitable care.*
- 6) *Be cognizant of the hierarchy of medicine and become familiar with the role you must play as a student in order to preserve the team dynamic. Know the power you have to effect change, such taking extra time with patients to dissolve misconceptions about healthcare, along with bringing attention to biases and toxic working environments in order to create positive changes.*
- 7) *Know where to turn for debriefing, help, and action: clerkship directors, Student Affairs, The Office of Diversity and Community Engagement, Ombudsperson, the hospital chaplain.*
- 8) *Reach out to and support each other*

WORKSHEET: Case development for Racial Bias in Medicine Small Group Session

<p>Theme:</p> <ul style="list-style-type: none"><input type="checkbox"/> Healthcare worker demonstrating bias against patient<input type="checkbox"/> Patient demonstrating bias against healthcare worker<input type="checkbox"/> Microaggressions or bias within the culture of medicine<input type="checkbox"/> Racial factors in the patient-physician power imbalance<input type="checkbox"/> Othering phenomenon<input type="checkbox"/> Other _____ <p>Case details:</p>	<p>Case development questions</p> <p>What made you think about racial bias in this case?</p> <p>What assumptions were made by the person(s) involved in this case?</p> <p>Who was harmed, and in what way?</p> <p>What could have been done differently?</p> <p>What elements of CHARGE²/INTERRUPT could be helpful?</p> <p>What resources could help students address and cope with a similar scenario?</p>
<p>Learning points and/or key take-away messages</p>	<p>Prompting questions</p>

that limit access to higher education and other opportunities.”

Microaggression Example and Theme	Third Party Intervention Example	Communication Approach
<p>Syllabus Repository: Faculty scolded, saying that overstepping for suggesting inclusive language/resources in the syllabus.</p> <p><i>Second Class Citizen</i></p>	<p>“I thought all syllabi need to include...?”</p> <p>Reach out to support her as Title IX is recommended language. “If comfortable, would speaker...?”</p>	<p>Inquire</p> <p>Revisit</p>
<p>Responding to a BIPOC faculty member wanting to include issues of BIPOC women in academic:</p> <p>“First, I’ll deal with the women and then the minorities.”</p> <p><i>Second Class Citizen</i></p>	<p>“With all due respect, Faculty lived experiences are very different and let me point out the way...”</p>	<p>Reframe</p> <p>Redirect</p>
<p>CONTEXT FOR SKIT: Grocery Store in a High-Income Neighborhood: Customer will not have any Mexican package her food. Loss Prevention/Profiling: BIPOC</p> <p>CHARACTERS:</p> <p>Manager</p> <p>Customer</p> <p>Check Out Clerk</p> <p><i>Second Class Citizen</i></p>	<p>SKIT: “I just had a conversation with this. Actually, the reality is that BIPOC do not steal any more than Whites.”</p> <p>“Do you think they are coming to steal bubble gum?”</p>	<p>Reframe: Look at the data that show BIPOC don’t commit crime at higher rates</p> <p>Use Humor</p> <p>See also: John Quinones show “What would you do?”</p>
<p>Boss making fun of accent.</p> <p><i>Pathologizing Communication Styles</i></p>	<p>“What would happen if...?”</p> <p>“How would you feel if...?”</p> <p>“I feel _____ when you make fun of my accent.”</p>	<p>Use Strategic Questions</p> <p>Reframe</p> <p>Use impact & “I” statement</p>
<p>Someone being surprised by the education level of a POC or a WOC.</p> <p><i>Ascription of Intelligence</i></p>	<p>“It sounds like you are surprised...”</p>	<p>Paraphrase/Reflect</p>
<p>A WOC from N campus is working in the science lab. Someone comments she doesn’t look like she belongs in the space or they are surprised she has a degree in the field.</p> <p><i>Traditional Gender Role Prejudicing & Stereotyping</i></p>	<p>“What do you think a person in the lab looks like?”</p>	<p>Inquiry</p>

Ascription of Intelligence

Add reference to Derald Wang Sue articles that catalogue RMAs and provide examples of ways to interrupt them.