Responding to anti-Black racism: an empirical appraisal of supervisors' behaviors using simulated encounters

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Research Article

Keywords: Anti-Black racism, antiracism, supervision, clinical care, medical education

Posted Date: November 28th, 2022

DOI: https://doi.org/10.21203/rs.3.rs-1844780/v3

Abstract

Background

Racist interactions in clinical practice remain a pervasive reality for Black healthcare providers.

Objective

We sought to provide supervisors with guidance to inform their actions when confronting racism in daily clinical practice.

Methods

We conducted in 2021 an empirical study in which experienced supervisors responded to seven short, videotaped interactions between 1) a simulated participant (SP) and different clinicians-in-training; 2) the trainees and their respective supervisors; and 3) the trainees and their supervisors together with the SP. The clinical exchanges exemplified different types of racist *(entrenching)*or antiracist *(uprooting)* behaviors. After viewing each clip, participants wrote their reflections confidentially before joining together for a structured debriefing. For our qualitative approach to the data we used thematic analysis.

Results

Based on the input of 52 participants recruited into five two-hour-long sessions, we categorized the behaviors of supervisors facing anti-Black racial injuries involving learners under their oversight. We organized supervisor behaviors into five interlocking domains, each with a range of possible responses: 1) *Gradation*: from conciliatory to confrontational; 2) *Explicitness*: from avoiding to naming; 3) *Ownership*: from individual to shared; 4) *Involvement*: from excusing to including; and 5) *Stance*: from protective to paternalistic.

Conclusions

Our qualitative findings provide a rubric for supervisors to engage in reflective practice and for medical educators to inform faculty development to fight anti-Black racism in clinical practice. In addition, they can serve as a framework for facilitated discussion among healthcare providers who may have experienced or witnessed anti-Black racist interactions.

Introduction

"…the manifestation of racism is both 'indiscernible,' yet noticeably evident depending on who you are—and more specifically, the color of your skin." [1, p. S6]

Anti-Black racism in the medical workplace remains a daily reality for many. Black medical students, residents, fellows, practicing physicians, patients, and staff experience routine acts ranging from micro-aggressions and racialized dismissiveness to overt aggression.[2–4] Hostile conditions met by Black medical professionals contribute to disparities in recruitment, retention, and representation at all levels of practice. Racism in healthcare negatively impacts minoritized employees' wellness and productivity and has a deleterious effect at the organizational level.[5] Efforts to address these serious problems have not had nearly enough impact on daily practice. For example, implicit bias training, emphasizing recognition rather than communication, behaviors, or other strategies for change, does not necessarily lead to better patient outcomes or measurable changes in the workplace.[6–8]

A promising way of addressing these challenges is by realigning efforts from a primary focus on increasing diversity in the medical workforce to an intentional stance on antiracist education and practice.[9,10] Antiracism, which posits that racial groups are equal and supports policies that reduce racial inequity,[11] is complementary to Critical Race Theory (CRT).[12,13] CRT considers race and racism from the perspective of power and larger historical determinants socially engrained over time. Reparative justice practices—based on the three tenets of acknowledging victims, taking concrete steps to repair harms, and validating victims as bearers of equal rights—can contribute to positive change in the learning environment through intergroup contact that emphasizes perspective-taking.[14]

In medical settings, a specific clinical challenge for supervisors is how to respond—in real-time, at the moment of charged affect—to racialized and hostile interactions involving trainees under their supervision.[15] Supervisors responsible for the oversight, protection, and support of their racially minoritized charges are often inconsistent in their approach and have limited guidance to inform their actions. Several useful approaches to deal with microaggressions and racism in the medical workplace have been put forth.[1,16–20] These studies predominantly focused on learners, rather than supervisors. The closest exception was a qualitative study in which medical students identified ideal responses by their supervisors to microaggressions.[17]

Intending to enhance supervisors' concrete tools to address racist interactions in the clinical workspace and to complement the works cited above, we designed an empirical study to assess the range of supervisors' antiracist behaviors. To this end, we used: 1) simulated patient encounters as stimuli for discussion; and 2) qualitative methods informed by a theoretical context of antiracism, CRT, and reparative justice practices.

Methods

Our study consisted of two distinct components: 1) creation of stimulus videos; and 2) qualitative analysis of data collected during five small group sessions in which experienced supervisors responded to seven short videoclips of paradigmatic racism-related behaviors.

Creation of stimulus videos

Our study is grounded in participatory action research (PAR),[21–23] an approach in which an intervention's intended beneficiaries are involved in its development. In this case, those beneficiaries included five Black female physicians who had experienced racist interactions during graduate training. They were central in developing scripts of racist and antiracist clinical interactions using the co-constructive patient simulation (CCPS) model.[24] The essence of the CCPS approach is the co-construction of case scenarios and learning objectives by the *learners*, rather than the instructors. We provide an expanded description about CCPS in **Appendix 1**.

Participants, study design, and qualitative analysis

We recruited volunteer participants through email solicitation, using listservs from the office of Graduate Medical Education and the departments of medicine, pediatrics, and child psychiatry at Yale School of Medicine. We specifically approached, in equal parts, faculty members with at least three of supervisory experience and senior residents or fellows with at least three years of postgraduate training. In addition, we opened recruitment to clinicians of similar seniority in other disciplines, including psychology, social work, and nursing. We informed participants that we would not collect any personally identifying information. The Yale Institutional Review Board approved the study (protocol # 2000030453).

We conducted five two-hour-long sessions every other week between July and September of 2021, following the study design outlined in **Table 1**. In phases I *(Clinical encounter)* and II *(Supervision),* participants viewed short video clips depicting vignettes demonstrating racist and antiracist clinical interactions, as exemplified by the same supervising clinicians. Following each video, they had two minutes to enter free text comments ($T_{1\text{-}4}$) into Qualtrics (Provo, UT) using their preferred WiFi-enabled device. Participants had the simple prompt to enter their reactions to the videos and any ideas of what they would have done differently if finding themselves in a similar situation. We conducted the study through synchronous video conferencing using Zoom (San Jose, CA). To prevent interaction during the first two phases, we asked participant to turn off their cameras and microphones.

INSERT TABLE 1 ABOUT HERE

After a short break between phases I and II, we presented a *Didactic* (III) developed with the goals of 1) enhancing education of the historical and current underpinnings of anti-Black racism in the medical system and how it fuels distrust among Black patients, 2) developing knowledge and skills to analyze racial disparities in medical practice through the lens of anti-Black racism, 3) developing the skills and tools to name racism and productively intervene in clinical settings in real time, and 4) examining antiracist attitudes and behaviors along a hypothesized continuum.[25] To exemplify best antiracist practices in clinical supervision, we incorporated three *uprooting* (disrupting*)* video conditions into the didactic. In this way, all participants got to see each of the three supervisors using both their *entrenching* (perpetuating) (II) and *uprooting* approaches (III). After a final *Debriefing* (IV), recorded and transcribed verbatim, participants completed their last free-text entry (T_5). The video stimuli and debriefing prompted participants to recall past experiences and reflection on what they saw and experienced during the

activity. We contacted participants two weeks after their session and encouraged them to provide any additional thoughts or reflections; we did not provide them with a specific prompt.

Data analysis was conducted using We approached data qualitatively using thematic analysis (TA),[26,27] a method that fosters flexibility in identifying underlying commonalities. Analyzing and writing occur iteratively in TA, which includes detailed accounts of the data undergirding specific themes. We addressed our own reflexivity[28] by focusing on emotionally-laden, complex, or ambiguous subject matter, i.e., considering rather than discarding our personal and subjective views as investigators. Two authors coded independently toward developing a joint codebook of overarching themes that reached theoretical sufficiency.[29] Our final domains and underlying themes are supported by multiple representative verbatim quotes.

Results

We received expressions of interest from 69 individuals, 52 (75%) of whom joined one of five sessions (median, 11 participants per session; range, 8 to 12). Volunteers were primarily physicians (n = 37, 71%), 19 of them senior trainees (37%). They self-identified as female (60%), Black (35%), and Latinx / Hispanic (13%). We intentionally oversampled Black participants: one-third in our sample, compared to the 2019 US census average of 13.4%. We developed a behavioral typology based on the qualitative analysis of participants' contributions. We analyzed 260 free-text entries (noted with an S, for "Session," in the sections that follow), five transcribed debriefing sessions (noted with a D, for "Debriefing"), and written reflections submitted by 32 (62%) participants two or more weeks after their index session (median, three weeks; range, 2 to 7; noted with an F, for "Follow-up"). We organized behaviors around five interlocking themes, each with a graded range of possible approaches supervisors could resort to when confronting similar challenges.

Supervisors' responses to racist actions

1. Gradation: from conciliatory to confrontational

In response to a racist interaction, an overt approach resonated with some participants on the "step in, step up, shut (him) up" (S1) side of the spectrum, one in which "my dignity is more important than my position," (S2) and where they deemed alternatives to confrontation as unrealistic. From this perspective, absent forceful engagement with its source would risk perpetuating and tolerating similar behaviors in the future—consistent with prior experience, in which little systemic protection had taken place:

Rather than negotiating or dialoguing with patients and their families, there needs to be a boundary of absolutely no tolerance. (S3)

Others worried about a sudden and uncalled-for rush to action, advocating instead for a measured approach. By adjusting the intensity and slowing the timing of the response, they sought to balance an overriding clinical duty to the patient with the necessary support of the trainee. They advocated for

behavioral scaling, concerned that forceful confrontation could exacerbate tensions and poor outcomes and defeat the building of necessary skills, such as alternative approaches through dialogue toward a middle ground of understanding:

A rush to action at the expense of reflection defies most models of leadership, which insist leaders must “get on the balcony” to see the whole picture before making a decision. How do we all become courageous instead of cowardly or rash in the face of conflict and injury is a core question here. My hope is that by pausing and going from the “arena” to the “balcony," we won’t be inadvertently deemed as racist and so foreclose dialogue, but instead move toward mutual clarification, support, and growth for all parties. (F1)

Participants who had been on the receiving end of racialized attacks one time too many had limited trust in conciliation and efforts that they considered coddling of the aggressor rather than supporting a trainee in a subordinate position and at a disadvantage to stand up for themselves. They wanted to return to their clinical duties unencumbered and protected from hurtful acts in which there was no moral equivalence between two sides: “Nasty racist patients are not going anywhere, but neither am I.” (S4)

INSERT TABLE 2 ABOUT HERE

2. Explicitness: from avoiding to naming

Talking about the emotionally charged topic of racism is inherently difficult. However, labeling inappropriate behaviors and hurtful actions can be a practical entry point. Just as language shapes our understanding of the world and our actions, terminology to deconstruct racialized acts can put into words what otherwise goes unsaid—but not unfelt. Most participants found the terminology of the didactic component to be helpful: differentiating racism from racist acts or considering alternatives to euphemistic terms (e.g., *"racism*-conscious" instead of *“race*-conscious"). Many agreed that acknowledging and addressing racism starts with naming actions for what they are.

Respondents differed in their views of when best to name terms explicitly and use them for good rather than potentially weaponize them. Some conceded that naming racism may or may not be advisable with the offending party in each clinical situation but must always be addressed when supporting the aggrieved party. For example, a supervisor who does not recognize a racial injury has work ahead and further personal growth; by contrast, a supervisor who *does* become aware of such interaction but does not name it contributes to an additional injury by making their supervisee feel unacknowledged, gaslit, dismissed—or retraumatized.

Validating the experience of the supervisee is essential, including by supervisors without personal experience on the receiving end of similar disparaging comments:

How can I protect somebody I supervise from something I don't fully understand? I can support them by listening and trusting their experience, as it is their life, not mine. (D5)

Indeed, the depiction of the dismissive response was considered more hurtful and ultimately more damaging than the initial racist injury: invisibility is invalidating, it cancels out and forces shut the experience. A point of consensus was that whenever invoking racism directly, the focus must be on the person's offensive behaviors, not on the person as the offense, on *racist acts*, rather than on the person as *a racist:*

I'm not saying you are a racist, but that what you did was racist. I'm not judging you as the person you are, but your actions were racist and hurtful to the doctor I'm supervising. (D6)

There was less uniformity regarding just when and how best to name racist acts directly with the aggressor: leaving things unsaid risks sanctioning behavior, normalizing it as either typical, expected, or an understandable reaction to stress. Such elisions could entrench views not only about racism but around any of the prevailing *isms* or *othering* perceptions, including sexism, ableism, homophobia, or xenophobia.

3. Ownership: from individual to shared

Participants concurred on the need for supervisors to take a direct stance, to "own" the interaction, and to lean into their protective responsibility. Nevertheless, they often felt left to their ingenuity, intuition, or interpersonal styles. Most yearned for policies and procedures to back their actions, for even imperfect guidelines setting realistic and appropriate boundaries. Involving intermediaries such as patient relations, security services, or an anonymous reporting system were all mentioned as steps in the right direction to support injured parties not to feel dismissed or isolated.

In turn, some participants questioned what would be the optimal approach for an aggrieved trainee to take. Moreover, who would be best to share the hurtful event with. Bringing up the issue felt tiring and burdensome to some; raising it with a supervisor potentially fraught with danger, risking “being labeled unprofessional, which is just code for an individual of color who stands up for themselves." (S10) Some shared a resigned, even defeatist sentiment of "having to work in elitist institutions where this form of invalidation is a daily struggle," (S11) and where aggrieved trainees all too often come to accept generic and avoidant feedback from their supervisors. They deemed the medical enterprise a "retail business in which ‘the customer is always right,’" (F3) leaving trainees in the vulnerable position of feeling unprotected. Feeling alone when confronting experiences involving racism resulted in a sense that they could trust only certain peers or select supervisors for empathy or support, yet rarely for addressing the source grievance. Supervisors who had used their authority / positions in a constructive way to combat this type of behavior were cited as all-too-rare exemplars.

4. Involvement: from excusing to including

When is it reasonable to include the racially targeted individual in addressing the encounter with its offender? In support of the inclusive approach, some participants saw a potential opportunity to model through visible actions, to have the trainee join in addressing the offense at its source. They hoped for supervisors with privilege to exemplify how addressing racism is work that should not fall entirely on those who are minoritized, as an opportunity to handle power differentials, to extend a learning opportunity to the trainee or the broader group of learners. However, the prevailing view supported a different approach: responding to the offender then and there—and at a separate time with the recipient. Several Black participants expressed doubt about not being harmed, let down, or abandoned once again, of entering a clinical space

that is never a safe environment. We might be told it is; we might like to think it is. It may be safe for some, but for those of us who are marginalized, it's not. (S12)

Other participants preferred decoupling the tasks of addressing the racist behavior with the aggressor, and processing the experience with the trainee, giving trainees time and space for reflection, gathering outside support, and gaining agency over what could be helpful as a next step. By listening first and acting only later, a supervisor could point out that support comes not only at that moment but just as importantly, between racist acts: “it’s for the long haul." (Debriefing 7)

5. Stance: from protective to paternalistic

Supervisors can become unwittingly overprotective and paternalistic in their effort to address a racist injury effectively when supporting their charges. Centering the response on the needs of their trainee is the first way to avoid that potential trap. For example, a supervisor who “just waltzes in to save the day" (S13) can convey that only they can make things better and that the aggrieved trainee is not up to the task. Moreover, the stance can become transparently performative.

Supervisors are most welcome when "validating, affirming, and witnessing, rather than when postulating or lecturing." (D8) They are protective; they inquire openly and confidentially about what is needed at the time; whenever possible embed their support within a longer-standing relationship; they realize the limitations and the risks of providing "total protection, which they really cannot promise" (D9); they are protective, but do not veer into protectionism. It is an admittedly narrow strait to navigate:

“How do I empower while being supportive at the same time? I want to be there for my trainee but don't want to be their rescuer, which could feel or come across as infantilizing.” (S14-Participant Free Text 14)

Discussion

The organization of behavioral responses we developed can provide a helpful rubric for supervisors confronting anti-Black racism in routine clinical practice. We discussed our findings from the perspective of the three theoretical frameworks underpinning our study: 1) reflective practice; 2) antiracism and critical race theory; and 3) reparative justice practices.

Reflective practice

Not intended as a rigid guideline, our behavioral organization can instead be construed as a rubric toward reflective practice. Supervisors can incorporate it expressly into a three-part approach first advanced by Donald Schön in *The Reflective Practitioner and later reflected in subsequent publications addressing the management of microaggressions in training*:[30] First, by inviting reflection *in* action (i.e., *while doing;* in this case, as racist actions and responses unfold in real time). Second, through reflection *on* action (i.e., *having done;* in this case, returning to the interactions with both the source and the recipient of the racialized injury). Third, and perhaps most important, to elicit and guide reflection *for* action (i.e., *towards doing*; in this instance, to inform and revise future behaviors by reaffirming or repairing previous actions). Indeed, the CCPS model on which the source video encounters were developed is specifically designed as a structured activity to improve reflective skills in practice. Initially applied to a child psychiatry context,[31] in this study we repurposed the same principles to examine supervisory responses to anti-Black racism.

At a practical level, the behavioral dimensions can serve as a framework for supervisors to engage in reflective practice and for medical educators to inform faculty development to fight anti-Black racism in clinical practice. Healthcare providers who may have experienced or witnessed anti-Black racist interactions can also use the range of behavioral responses as a basis for facilitated discussion.

Antiracism and critical race theory

Antiracist work is not any single group's exclusive responsibility. Black supervisors, for example, are not inherently antiracist in their interactions, and failure to address racism effectively (as exemplified in our stimulus video of internalized racism) can cause further damage through intragroup cultural betrayal.[32] In turn, non-Black supervisors need to commit to the iterative nature of antiracism, work that requires an enduring commitment to action and recursive learning and self-reflection: "not a state of being that, once achieved, is static and unchanging…allyship should be thought of as a verb, not a noun."[33] A necessary first step in the work of antiracism is acknowledging one's own racist behaviors, embedded within a larger socio-historical context from which non-minoritized groups inherently benefit.[13] A concrete corollary of this statement is that institutional buy-in can be critical; and yet, settings that are less welcoming or encouraging of antiracist initiatives and policies may be the ones needing them most.

We consider antiracism a lifelong journey of developmental progression rather than an ultimate point of arrival.[25] Our understanding revolves around racist *actions*, not of *individuals* as racist: one racist action does not a racist make. Do two or three, do ten such actions? We find it more constructive to think of actions as either *entrenching* or *uprooting* racism. Discrete *actions* can be construed in the binary of racist or antiracist, as has been advanced by Ibrahim X. Kendi.[11] And yet, those discrete behaviors do not add up to a categorical view of an *individual* as a racist or an antiracist; instead, as falling somewhere along an antiracist continuum that can be improved upon as a lifelong, perfectible goal. Consistent with that view and with the underlying tenets of PAR,[21–23] the ultimate use of this behavioral appraisal will be to incorporate it into the practice of its participant-beneficiaries and fellow practitioners.

Reparative justice practices

The actions of a supervisor can be considered from two interdependent angles: the need for a *response* to the situation at hand and the need for *repair* with the targeted trainee. Reparative work is essential to concretize the commitment to support and protect, lest further traumatization occur through personal or institutional omission:[34,35] supervisors need to be deliberate in checking in and following up. Repair can, and ideally should be extended to the community of learners so that everybody can benefit in a virtuous cycle. Beyond initiatives aimed at advancing diversity, equity, and inclusion, reparative justice practices are necessary to increase the representation of Black physicians in medicine.[36]

We recognize four main limitations. First, our stimulus videos depicted overt anti-Black racist interactions and encompassed additional elements of misogyny and xenophobia. They portrayed one extreme in the continuum of anti-Black racism—but not the most pervasive. Robin DiAngelo has described the perils of "nice racism," a more subtle and insidious form in which individuals or groups shield behind an appearance of civility that protects from the "honesty and vulnerability needed for growth and change."[29] Second, we drew our sample from a single institution, reflecting circumstances unique to its environment and region's geopolitical history and current realities. Third, we are aware of the bias inherent in selecting volunteer participants, exemplified by the absence of the black male representation in our sample.[37] When initially approached, potential participants knew of a research study to address "clinical supervision in real time," but with no explicit reference to anti-Black racism. As a result, our sample represents self-selected supervisors motivated to enhance their skills. Finally, releasing time to incorporate this training session as a standard component in an already stretched curriculum and busy clinical practice can be challenging.

Conclusions

Our work builds on the foundations by other scholars seeking effective approaches for dealing with racism in clinical settings. The behavioral dimensions we describe can be incorporated and synergize those other approaches, particularly given a commonality in theoretical underpinnings. For example, one group used a before / during / after approach for residents to confront “problematic behaviors”[16] organizing responses along a timeline reminiscent of reflective practice.[30] A second group used simulated encounters to improve resident preparedness to discriminatory comments in the workplace.[20] Two other groups[1,17] have incorporated antiracism, CRT, and reparative justice into their efforts. The twelve tips from another group incorporate practical highlights that cut across the other approaches.[19]

Our work advances previous efforts in three main ways: 1) it is one of the few studies to derive its approach through an empirical design, and to do so using simulation; 2) few other studies address anti-Black racism exclusively, rather than non-specific racism or microaggressions broadly defined; and 3) to our knowledge, ours is the first study centered on supervisors, rather than on students or residents. These innovative aspects could be complementary to the work outlined above.

Notwithstanding their shortcomings, our findings can provide a rubric for supervisors to engage in reflective practice, which can in turn inform their actions when next called upon to address anti-Black racism in clinical practice.

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Tables

TABLE 1

Research study design

ssion ts:	I. Clinical encounter	II. Supervision			III. Didactic	IV. Debriefing
rticipants:	CiT 1 & Patient (actor)	CiT 2 & SUP_1 (white male)	CiT 3 & SUP_2 (white female)	CiT 4 & SUP_3 (Black female)	CiT_2, CiT_3, or CiT_4 & SUP_1, SUP_2, or SUP_3 & Patient	N/A
haviors mplified:	Racist confrontation	CiT_2 – Freeze & SUP_1 - Entrenching			CiT_2 – Freeze & SUP_1 - Disrupting	
			CiT_3 - Flight / Fawn & SUP_2 - Entrenching		CiT_3 - Flight / Fawn & SUP_2 - Disrupting	
				CiT_4 – Fight & SUP_3 - Entrenching	CiT_4 – Fight & SUP_3 - Disrupting	
deo type: *ration m:ss]*	Stimulus *[5:40]*	Stimulus *[3:40]*	Stimulus *[3:38]*	Stimulus *[5:13]*	Didactic *[5:33], [5:57], [7:21]*	N/A
ee-text nments:	T_1	T_2	T_3	T_4	N/A	T_5
ne *(mm, 0 total[a]):*	10	35			35	35

Abbreviations: CiT – Clinician-in-training (each of the four a Black female physician); SUP – Supervisor; T – Time point.

[a] There is a 5-minute break between phases II and III.

Note: Two weeks after the session, participants are approached to provide any additional free text comments.

TABLE 2

Supervisors' behavioral responses to racist acts in clinical practice

Domain *(range)*	Sample quotes
Gradation	
Conciliatory	It's never the message; it's always the delivery. We can say these things without our pride as supervisors competing and spiraling into a battle of ideologies. I don't know how much is won by that. (S5)
Confrontational	You assert your authority as a boss, a white boss, a non-Black boss—notice I said non-Black boss—that's intentional, and you say, "We will not accept this behavior." Period. If you can't do this, if you can't stop being racist, you can leave. We will take care of your child, but you cannot stay here. If necessary, we will call security. (S6)
Explicitness	
Avoiding	Naming racism and racist behaviors always gets an emotional response. We can confront racism without the emotions unleashed by naming it, which often obscure the problem and prevent possible solutions. (S7)
Naming	Why should I have to couch my response in terms that are "comfortable" for this aggressor? Why indeed? (S8)
Ownership	
Individual	I want to be supportive, but I don't want to be the rescuer, the "white savior". How do I empower, but still be supportive at the same time? (D1)
Shared	It is important to know what kind of support you get from the power structure in that institution because I've seen too many times where you will confront somebody and take a stance about their behavior, but because they're threatened, then somebody who's higher up comes along and tells you what you've done is not correct. And they validate their behavior by saying it was acceptable and yours was not. You need a supportive power structure. (D2)
Involvement	
Excusing	You don't want to put such a toll on the person at that moment; you need to give them space and time to express what they want, with whom they want, at the moment they want. (D3)
Incorporating	Having the discussion with the trainee in the room addressed the reality of the hostile work environment in which they work and recognized the strength it took as a person of color to speak up in this way. (S9)
Stance	
Protective	Listen and affirm; do not direct, postulate, pontificate. (D4)
Paternalistic	Is the pursuit of total protection from any type of harm the best goal to support trainees' entry into attending and leadership roles? When does supervisor protection veer into protectionism

	akin to a parent-child relationship instead of working together as colleagues in a shared struggle to end all *isms*? (F2)

Abbreviations: Verbatim quotes derive from one of three study phases: S = Session; D = Debriefing; and F = Follow-up. The adjacent numbers are sequentially generated and not linked to any given session or participant.

Figures

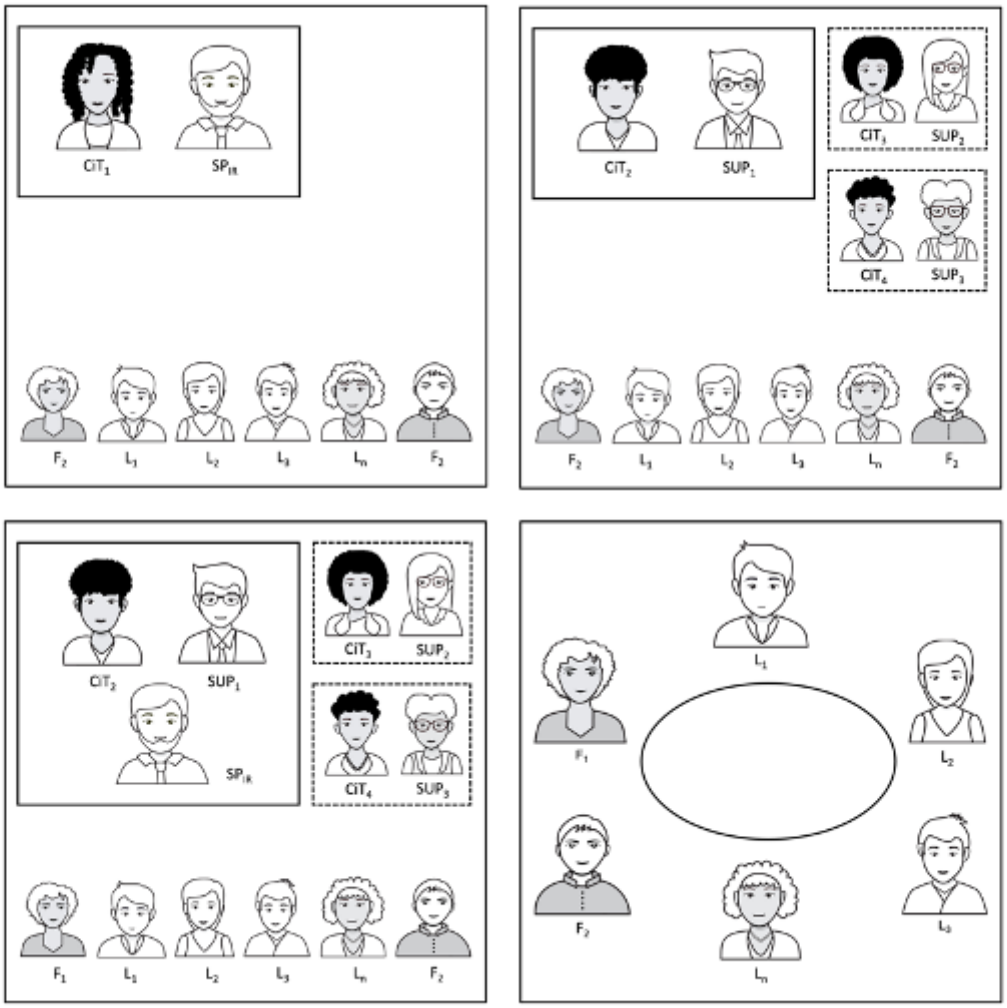

Figure 1

During the reflective session, learners ($L_{1\text{-}n}$) and facilitators ($F_{1\text{-}2}$) view and react to videotaped interactions, indicated by solid-line enclosing boxes. Four component CCPS phases are depicted clockwise from the top left: I. Racist clinical interaction between a clinician-in-training (CiT_1) and a simulated participant-in-role (SP_{IR}); II. Three different supervisors ($SUP_{1\text{-}3}$) demonstrate *entrenching*

(racist) responses as they respectively meet with one of three alternative clinicians ($CiT_{2\text{-}4}$; dashed-line boxes represent recordings of alternate clinician-supervisor pairings); III. $SUP_{1\text{-}3,}$ this time modeling *uprooting (antiracist*) responses, return with $CiT_{2\text{-}4}$ to meet with SP_{IR}; IV. Facilitators ($F_{1\text{-}2}$) moderate debriefing sessions with all learners ($L_{1\text{-}n}$).

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- APPENDIX1.docx