

A PIECE OF MY MIND

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My Name Is Not “Interpreter”

The day I completed my sociology dissertation, I felt like a king. I was one step closer to finally accomplishing my dream of becoming a physician-scientist. To complement this feeling of royalty, my wife and I found ourselves invited to an upscale restaurant—a faculty member’s treat for this joyous occasion.

We excitedly got ready and we looked sharp: she, resplendent in a lovely cocktail dress, and I, sporting my skinny suit, the gray one—the one that made me feel like a GQ model.

We ate. We drank. We laughed!

We graciously thanked our host for the perfect celebration to a hard-won life event and left the restaurant. Locked arm-in-arm, my wife and I waited for our car at the valet curb with the other couples in their fine attire.

We watched the hard-working valets, who I realized look like my family members and friends back in East Los Angeles. They shuttled back and forth from their wooden kiosk to the luxury cars belonging to people who do not look like the valets, who do not look like me.

Rapid exchanges of keys, slips of paper, and money. I admired their efficiency.

A Jaguar snaked up to the curb.

A woman dressed in a sparkling black gown stepped out. She bypassed the bustling valet dock, rushed past the two couples in front of us, stopped for a second in front of me, and dropped her keys into my somehow receiving hand.

Before my jaw had time to drop away from my face in awe and protest, she walked away without a word. She didn’t even wait to get a slip from me—the person she mistook for the valet. My face turned beet red. My heart was pounding. I felt enraged, frustrated. I became paralyzed and mute. I was dumbstruck, mortified. I was hurt.

In silence, I walked to one of the attendants and handed him the woman’s car keys. “No, these aren’t mine. We are waiting for our car.” He looked at me and I looked at him and something passed between us. Recognition. It’s probably not the first time he had seen this happen to a Latino man. He nodded his head and placed the keys with the others.

Not even five minutes later, with just one couple ahead of us in line, another well-dressed woman approached me. She handed me her car keys in almost an identical fashion. This woman, however, recognized the pain on my face. She quickly took back her keys.

“I’m sorry,” she said.

The woman behind us whispered to her partner, “Oh my god.” They turned their heads away from us as if to somehow shield their embarrassment for me, from me.

The drive back home was silent and stiff. What do I say? What can I say? I was at the pinnacle of my celebration, and with one swift action, I was dismissed. I was made invisible. I was negated.

I had worked so hard for what I was celebrating; my body, however, fully defined me in that moment—I was lumped into a category based on my appearance, my ethnicity. This is not to diminish the men and women in service jobs, but I was left with one thought: Will I ever be good enough? I was flooded with feelings of inferiority, helplessness, sadness, and anger. As I stared ahead at the road, I contemplated these scattered emotions in solitude until faint sounds of my wife crying replaced the silence. This wasn’t the first time she saw me being mistaken for someone with a service job. Before words of comfort had a chance to form in my mouth, she lightly placed her hand on mine and said through her constricted throat, “This is never going to end.”

Unfortunately, these types of experiences are not absent from medical care or training. For the past two years, I have begun to bridge my two worlds: my PhD training as a sociologist specializing in discrimination and racial and health disparities and that of a physician, a budding psychiatrist. I have begun to examine medical trainee experiences of discrimination based on race, gender, and sexual orientation. I hope to document the accumulation of microaggressions that underrepresented trainees experience during their training and demonstrate the impact this has on their mental health and well-being.

We are all, in one way or another, familiar with these subtle slights—known as microaggressions. The women in the above examples were most likely unaware of their actions—they were probably not meaning to discriminate or even to be rude, but they nonetheless inflicted harm through their unintentional expressions of their racism. Coined by psychiatrist Chester Pierce and colleagues,¹ *microaggression* was defined as casual racism and later expanded to include casual debasement of any minority group. Unlike overt discrimination, they contend, microaggressions are “subtle, [...] often automatic, non-verbal exchanges” that “infringe on a person’s [...] space, energy and mobility.” Subsequent work by psychologist Derald Sue and colleagues² expanded the definition to “brief and commonplace verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group.”

Microaggressions go beyond race and extend into socially constructed identities that embody privilege in different ways, such as income, social capital, religion, ableness, gender, and sexual orientation.³ These acts do not respect boundaries—they exist in our personal, academic, and work lives and are detrimental to the training and well-being of our colleagues and trainees.⁴

Medical institutions can create environments that either facilitate or curb microaggressions. As a medical student, I often felt marginalized from my medical

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community. I have been told that my name is “not American,” fallen prey to being confused for support staff such as a janitor (even while wearing my white coat), and been asked questions like “Where are you really from?” or “How old were you when you moved to the United States?” or “When you’re done with your training, are you going back to your country?” The greatest barb, however, was being summoned as “interpreter” by an attending physician during my surgery rounds.

“Interpreter!” he would bark out. I instantly appeared before the group and would begin to interpret.

I dreaded the days I had to work with this attending. Like most other recipients of microaggressions, I was stuck trying to decide if and how I would respond to these comments, especially in such a disproportionate power dynamic. Is he trying to help me by showcasing my language skills? Is he just trying to be funny? Am I overreacting? Will I be perceived as “the angry minority” if I speak up? At these instances, I felt helpless and powerless—there were no open conversations about racism, and I was left alone to deal with these difficult situations.

I do not believe that many of these assumptive comments and/or questions—like many microaggressions—were or are meant to intentionally hurt me; but they did and they do. I am made to feel that because of the color of my skin, my very subtle “Mexican” accent, or because I speak Spanish, I function in a support capacity and not as a physician. The sense of “otherness” builds with every occurrence, be it overt or accidentally scarring. Microaggressions often catch trainees off guard. They silence us and enforce an uncomfortable environment that is not conducive to professional development.

As a resident, I naively thought these unfortunate life circumstances would become less frequent. They have not—they just morph into other forms of microaggressions.

While on my internal medicine rotation, for instance, after presenting my assessment and plan to an attending physician, he responded with a football analogy that I did not understand. His reply: “Oh, I’m sorry. That’s right. In your country it’s the other football. Soccer, right?” I had never worked with this attending; he knew nothing about me other than my name and what I looked like.

Preliminary findings from my current study suggest that I am not alone in my experiences. Other trainees have reported similar occurrences with other co-residents or attendings:

“You speak English really well,” to someone born and raised in the United States.

“Are you a nurse?” to a female resident examining a patient.

“Are you the sitter [an aide who monitors patients at risk for suicide]?” to a black female resident examining a patient.

“You look too masculine,” to a self-identified lesbian resident.

“Minorities are still hung up on race,” to a fellow resident.

As benign as some of these experiences may appear, there are cumulative sequelae from these microtraumas. As physicians or physicians in training, it is imperative that we expand our vocabulary, knowledge, and empathy, as well as our ability to recognize, examine, and address microaggressions in medical settings.⁵ Acknowledging that we all have biases and that we all commit microaggressions is an important first step in facilitating a good training environment.

However, it is not sufficient merely to acknowledge that microaggressions exist. Each of us must strive to become an ally in creating an environment that promotes a medical community of safety, advocacy, and compassion. I want to be able to walk down a hospital corridor and not have others assume that I am a valet attendant, janitor, or interpreter. Until then, I would like to invite you to help widen the discourse on the subtle yet destructive acts of microaggressions and consider ways in which we participate—as either the receiver or the aggressor, and most often both—in the medical community and beyond.

With that, I will confess that I, a Latino man and researcher of discrimination, commit microaggressions. A few months ago, while casually talking to one of my co-residents in a seminar, I called her Tammi. Her name is Kali. Tammi is another co-resident who happens to be the only other young, black woman in my cohort. The second I caught my infraction, I self-corrected with a stammering and mortified, “I mean Kali! Sorry, I meant Kali!” Mind you, this was not my first time making this mistake.

To many, this may appear a negligible mistake. To Kali, however, my oversight (or rather undersight) was an aggression, an attack on her identity. She expressed that my repeated confusion of her name was hurtful—“Do you think all black people look alike?” she asked.

I was embarrassed but grateful that she had the courage to broach this difficult conversation. She in turn appreciated that I was not only apologetic, but that I no longer attempted to rationalize, minimize, or even dismiss my mistake. We were able to process this experience as recipients and aggressors.

I challenge us to reflect on how we perceive each other and ourselves in relation to each other (eg, by ethnicity, class, sexual orientation, ability) in order to shift the conversation of microaggressions from taboo to mutual understanding. I have no doubt that in our practice of healing, we have the capacity to compassionately listen to one another and further this discourse for the sake of our trainees, colleagues, patients, and profession.

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