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ORIGINAL RESEARCH

The Impact of Biases for Early-Career Women in Medicine: "It's the Little Day-to-Day Microaggressions"

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Background: Women physicians face multiple systemic and social biases in the clinical setting that erode mental and physical well-being. Gender-based discrimination was reported by 76% of early-career women physicians, decreasing to 57% for mid-career, and 36% for late-career. While these trends suggest that these biases may diminish with career progression, they remain a persistent burden of women physician's careers. This article offers a unique contribution by centering early-career women family physicians, a group underrepresented in qualitative research on workplace bias. This article focuses on participants' microaggressive experiences in the clinical setting to better understand the biases they face.

Methods: Via email we recruited 25 geographically and racially diverse early-career women physicians who responded to the 2021-2023 American Board of Family Medicine National Graduate Survey. A semi-structured interview guide was developed following a life-history approach to better understand the transitionary phase from residency to the practicing workforce. Interviews were transcribed verbatim, cleaned, and analyzed via Inductive Content Analysis in NVivo by qualitative researchers.

Results: We identified three main themes that emerged from the data. First, biased communications within the clinical setting exposed a pattern of gender bias. Second, patients invalidate physicians' positions based on appearance and perception. Third, women physicians described navigating the emotional and psychological labor of clinical and societal expectations.

Conclusion: In the context of primary care, microaggressions demand direct and intentional intervention. Failing to address these experiences jeopardizes both equity and workforce sustainability. Leadership must be equipped to recognize, interrupt, and respond to microaggressions—not only to support individual clinicians but to strengthen organizational culture and the broader primary care mission. Interference reflects the broader societal imperative and commitment to equity in healthcare.

Keywords: Career Counseling, Diversity, Family Medicine, Gender Differences, Health Workforce, Physicians, Primary Health Care, Qualitative Research, Social Justice, Women Physicians

Introduction

Women physicians face multiple systemic and social biases in the clinical setting that erode mental and physical well-being.[1-3] Such biases compromise psychological safety,[4] self-perceived well-being,[5] and increase burnout due to "chronic, severe stress."[6] Women who experience workplace biases can develop hypervigilance—always being alert to potential slights, assumptions, or stigma.[7] Female physicians often experience greater pressure to engage in emotional labor due to gendered societal norms and expectations. For example, they spend nearly 16% more time with each patient.[8] Previously identified emotional and social burdens experienced by women physicians include imposter phenomena,[9] pay expectation gaps,[10] and microaggressions.[11]

For early-career women physicians, 76% reported gender-based discrimination, compared to 57% in mid-career and 36% in late-career. Similarly, age-based discrimination with verbal abuse or bullying was reported by 22% of early-careers, 10% of mid-careers, and 13% of late-career women physicians.[12] These numbers illustrate how these biases faced by early-career women may fluctuate over time, but do not disappear. According to this article, bias reporting fluctuates over career stages, but these numbers are likely underreported and may reflect normalization over time.

Workplace biases follow them throughout their careers, leading to long-term implications for physician mental and physical wellness.[13] Additionally, early career physicians may be more attuned to recognizing, responding to, and reporting microaggressions due to their proximity to training and an evolving societal discussion. Microaggressions were originally defined as "subtle and stunning" offenses that negatively impact well-being.[14] While initially used to describe racial discrimination, this definition was later expanded to include discrimination based on gender identity and the ways in which women are made to feel overlooked, disrespected, and dismissed.[15]

In healthcare settings, microaggressions manifest in multiple forms of discrimination, from various roles across the healthcare hierarchy, reflecting personal and systemic prejudices.[16] Women physicians reported significantly higher gender-based microaggressions from patients than their male counterparts.[17] Women who are underrepresented in medicine (URiM) face heightened discrimination due to the intersection of multiple identities, such as race, gender, and age in traditionally white male hegemonic settings.[9,18] The Association of American Medical Colleges (AAMC) defines URiM as "any individual who self-identified as one or more of the following race/ethnicity categories (alone or in combination with any other race/ethnicity category): American Indian or Alaska Native; Black or African American; Hispanic or Latino; or Native Hawaiian or Pacific Islander."[9] This definition was set intentionally to guide discourse away from "minority" terminology, which can carry negative undertones, towards more inclusive language that reflects proportional representation and value found in diversity. As aspirational terms are set, reality still permeates the clinic for URiM family physicians, especially in high-volume, patient-facing roles, which can directly impair clinical function, collegial trust, and long-term retention.

Previous studies explored the prevalence and effects of microaggressions with residents and faculty physicians.[11] These studies provide compelling quantitative and limited qualitative findings in the primary care setting. However, there remains a notable gap exploring microaggressions experienced by early-career women physicians. This article focuses on participants' microaggressive experiences in the clinical setting to better understand the biases they face.

Methods

This research represents a component of a broader qualitative investigation examining the gender pay gap in family medicine using a methodological framework informed by feminist theory and critical theory. Participants were recruited from three cohorts: the 2021, 2022, and 2023 National Graduate Survey (NGS), both administered by the American Board of Family Medicine (ABFM). Initial recruitment occurred via email over a three-month period. Selection criteria included: (1) self-identification as a woman; (2) early-career status (3-5 years post-residency); (3) current income below the US family physician average of $250,000; and (4) current workload exceeding 40 hours per week. In 2024, all 25 participants were geographically diverse, early-career women physicians who held American Board of Family Medicine certification. We emailed a random sample of 117 physicians from the 2022 NGS who met eligibility criteria. In an effort to address the absence of Black early-career women physicians in the initial study,[10] we employed targeted recruitment using the 2021-2023 NGS database, contacting 36 Black women physicians who met initial criteria, resulting in six Black participants to fill the previous lack of Black representation. Demographic information was collected from ABFM internal administrative data as close-ended categorical variables in a "select best" format. The final sample consisted of 25 diverse women family physicians.

Semi-structured interviews lasting on average over an hour were conducted via Zoom between 2023-2024 (AK). All interviews were recorded and transcribed verbatim and uploaded to NVivo for analysis. Two qualitative researchers (AK, MF) conducted iterative data analysis utilizing inductive content analysis (ICA) methodology, with additional analysis by secondary coders (MB, AS). The ICA approach involves data familiarization, thematic organization via codebook formulation, creating subcodes, followed by synthesis and interpretation. The primary qualitative researchers (AK, MF) developed the initial codebook from initial interviews, resolving all coding discrepancies through discussion until achieving greater than 90% agreement. This study was approved by the American Academy of Family Physicians Institutional Review Board. For additional information on methods please refer to Koempel.[10]

Results

Table 1 presents participant demographic data. All participants (n = 25) self-identified as women; a majority practiced in the West and worked in a hospital or hospital-owned practice in an urban area. These early-career physicians reflected the larger sample of demographics from which they were recruited.

In this study, we identified three types of microaggressions: biased communications within the clinical setting, patients invalidating physicians' positions based on appearance, and navigating the emotional and psychological labor of clinical and societal expectations.

Biased Communications Within the Clinical Setting

Many physicians described subtle, overt, biased forms of verbal communication within the clinical setting that reduced women to their biological sex. These patterns of biased communication—from hiring interviews to daily interactions—illustrate how gendered expectations are embedded at every level of the clinical environment, shaping physicians' experiences even before employment begins. In addition to experiencing gender bias within the clinic, one physician explained how she experienced biased questioning in her interview with her current employer. She interviewed with two male physicians, both of whom fo-

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Table 1. **Race and Practice Information of Respondents to the 2021-2023 American Board of Family Medicine National Graduate Survey (Early Career) (n = 2,702)**

		Interviewed and Income < $250k		All Incomes
		No	Yes	
Total		2,002	25	2,702
Race n (%)	American Indian or Alaska Native	12 (0.6%)		18 (0.7%)
	Asian	411 (20.5%)	4 (16.0%)	565 (20.9%)
	Black or African American	177 (8.8%)	6 (24.0%)	255 (9.4%)
	Native Hawaiian or Other Pacific Islander	3 (0.1%)	1 (4.0%)	4 (0.1%)
	Other	142 (7.1%)	2 (8.0%)	187 (6.9%)
	White	1,257 (62.8%)	12 (48.0%)	1,673 (61.9%)
Rurality (RUCC) n (%)	Metropolitan	1,717 (89.2%)	22 (88.0%)	2,255 (86.4%)
	Nonmetropolitan	207 (10.8%)	3 (12.0%)	355 (13.6%)
Principal Practice Site n (%)	Academic health center / faculty practice	302 (16.6%)	6 (24.0%)	350 (14.8%)
	Federal	82 (4.5%)	1 (4.0%)	85 (3.6%)
	Federally Qualified Health Center or look-alike	313 (17.2%)	2 (8.0%)	349 (14.8%)
	Government clinic, nonfederal	18 (1.0%)		27 (1.1%)
	Hospital / health-system owned medical practice	655 (35.9%)	8 (32.0%)	885 (37.5%)
	Independently owned medical practice	224 (12.3%)	4 (16.0%)	289 (12.2%)
	Indian Health Service or tribal health clinic	8 (0.4%)		14 (0.6%)
	Managed care / HMO (Health Management Organization) practice	86 (4.7%)	2 (8.0%)	139 (5.9%)
	Other	48 (2.6%)		65 (2.8%)
	Rural health clinic (federally qualified)	52 (2.9%)	2 (8.0%)	119 (5.0%)
	Work site clinic	34 (1.9%)		41 (1.7%)
Region n (%)	Midwest	443 (23.2%)	4 (16.7%)	612 (23.6%)
	Northeast	293 (15.3%)	6 (25.0%)	360 (13.9%)
	South	623 (32.6%)	6 (25.0%)	845 (32.6%)
	West	554 (29.0%)	8 (33.3%)	779 (30.0%)

cused on her "parenthood plan" and overall personal future. These assumptions, or rather preoccupations with women having children, signaled the inherent bias women face prior to entering the workforce.

> *"So I had two main interviews in the end, and both of them were mentioning the parenthood plan, not anything immediate but you know that is kind of the plan in the future. They're both guys that I interviewed with. One was saying, as if he knew that he wasn't supposed to ask..." (33 year old, Midwest, Independent Practice, Urban, Black)*

These experiences persisted throughout the employment process, demonstrating how subtle forms of discrimination were normalized within the clinical environment. One participant noted how frequently these paternal com-

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ments were made in her clinic and emphasized the growing impact that it had not only on her, but on the entire department.

> *"It's just the little like day-to-day microaggressions that are frustrating. Our FMOB director was like asking another one of our women colleagues, who was pregnant, and was trying to purchase pelvic models to do our simulations for the labor floor. He was like, oh, you must be nesting. Weird offhand comments like that, on a daily basis, that are intangible. I think over time … they build up and you get worn down."*
> *(32 year old, Northeast, Academic Health Center, Urban, Asian)*

Biased communication occurred across multiple levels of administration. One physician recounted her clinical director stating that he had never experienced conflicts with her predecessor, a male medical director. These passive remarks led her to question whether these disagreements stemmed from his personal bias or from her tenure in the position.

> *"I think right now, in my new role, in taking over for a man, it feels a little bit different. And I think he had a very different approach than I do…. It's just like [being younger] and the fact that I'm a woman, which is a little bit different than our old medical director, I think has made it a bit challenging….This current clinical director has made several comments to me about the fact that he has always seen eye to eye with our previous medical director….They always agreed on everything. He's really struggling with the fact that I don't always agree with him on things, and I can't tell if it's just because I'm new to this role."*
> *(37 year old, West, Hospital/Health System Owned Medical Practice, Urban, White)*

Subtle, negative remarks not only came from those in positions of power but also from other members of the clinical care team. One of our participants explained how gendered and racist comments from nurses towards physicians contributed to a growingly problematic labor floor. Despite traditional hierarchies within medical institutions, where physicians occupy positions of authority over nurses, microaggressions flowed up the power chain and drove faculty to resign and caused residents to consider leaving.

> *"I don't know why our labor floor is so problematic, recently we've had a lot of instances, a lot of remarks from the nurses to our residents and attendings that have been pretty gendered and also racist…. Multiple of our faculty have left because of it, and some of our residents haven't wanted to stay because of it."*
> *(32 year old, Northeast, Academic Health Center, Urban, Asian)*

Participants overwhelmingly recognized the problematic nature of these biased communication patterns, while simultaneously acknowledging the harmful impacts they incited. Such communication reduced women to their biological functions through discussions of pregnancy and childrearing. Additionally, these encounters often carried assumptions of incompetence, undermining their expertise solely based on gender.

Patients Invalidating Physicians' Positions Based on Appearance

Invalidation of physicians' positions based on appearance within the workplace occurred across racial identities, practice regions, and practice types. Patients perceived role incongruence and occupational stereotyping largely due to the gender and/or racial identity of the physician. Across various clinical environments, physicians found themselves overlooked or discredited. Patients questioned their medical credentials, simply due to their gender presentation, and these experiences were compounded by their early-career status. As one physician shared, patients struggled to believe that she was a doctor due to both her age and gender.

> *"… people think I'm younger than I am, and oftentimes they will mistake me for doing a role that is not mine. [They] ask kind of in disbelief—are you the doctor?"*
> *(35 year old, South, Academic Health Center, Urban, Black)*

Insensitive questions informed by underlying assumptions about what a doctor "should" look like were a common theme for many participants. Some physicians attempted to pre-empt invalidations by prominently displaying their badge or wearing a large pin with the word "doctor." A physician explained how even when she purposefully utilized physical identifiers to circumvent discrimination, she would still encounter resistance and disbelief.

> *"… there's a lot of little rules that I made for myself…. I have my badge, it says Doctor, there's still people who are like, where's the doctor? That's such a common experience for women of color and people of color. So yeah, that's ever present. Not that it's something in every interaction, but you know it's in the background."*
> *(44 year old, West, Hospital/Health System Owned Medical Practice, Urban, Black)*

Even when patients were aware that they were speaking with their doctor, personal boundaries were frequently crossed. Participants shared that patients made inappropriate comments about their appearance, asked intrusive questions about the physician's personal life, and made assumptions about their identities. A participant clearly articulated this overstep and questioned whether her male colleagues would be subjected to similar probing.

> *"… Patients will ask, do you have kids? How many kids are you having? When's your next kid coming? Or, how old are you? Based on the way that I appear, people assume that I speak certain languages. They'll say, you must speak this, right? Some of those things [are] related to being a woman. Some of those things are not related to being a woman, but I don't think patients would be so forthcoming with those questions with a man."*
> *(35 year old, West, Academic Health Center, Urban, Other)*

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These interactions were predominantly rooted in gender- and age-based appearance assumptions; they were impactful enough that some physicians proactively sought to mitigate potential misidentification or invalidation. Patients fundamentally altered the patient-physician relationship and dynamics by overstepping professional boundaries through intrusive questioning. In observing these trends of inappropriate personal questioning, physicians speculated whether their male colleagues faced similar challenges and comparable instances of boundary-crossing behaviors.

Navigating the Emotional and Psychological Labor of Clinical and Societal Expectations

Participants highlighted the additional burden that requires women physicians to manage others' feelings, anticipate needs, maintain interpersonal harmony, and navigate societal expectations. These expectations were so subtle that they were sometimes overlooked by participants even as they identified them within the same conversation. These presumptions reflect broader societal norms that impose similar emotional expectations on women across all professional and personal contexts. One physician observed that these expectations, like using a certain tone with staff, extend beyond the clinic and permeate everyday life.

> *"As I've observed generally in my career there's a lot less resistance to … what tone someone took, what exact words, or how many pleases were included if they're male. At our site though, again, because of the high co-occurrence between leadership and male gender, it would be very hard to separate that out. But how staff would treat a female CMO versus our current ones—and just kidding, that would never happen.… I don't feel like I face a ton of gender discrimination again, because it's more those like little subtle things of staff needing a certain tone from you. I don't know, those are minor things that are also just general life things, and they aren't as much about the workplace."*
> *(34 year old, South, FQHC, Urban, White)*

Other physicians expressed frustration with what they perceived as outdated societal expectations, citing standards that undermine their expertise and position by reducing them to their biological sex. A participant elaborated on a discussion that she had with a colleague about this issue:

> *"I think it's this pull between, when you are female, like society sees your job as really more to run a home, raise children, and do all this stuff that I think a lot of us thought, aren't we done with that? Didn't that end? But no, those expectations are still very much there, and they might be a little more coded. But they are very much there."*
> *(37 year old, West, Managed Care/HMO, Urban, White)*

In addition to navigating societal expectations, Black physicians described navigating added layers of clinical expectations. One physician expanded upon this additional complexity with a reflection about caring for her own racial/ethnic community. She grappled not only with the emotional labor involved but also with her colleagues who unintentionally offended her.

> *"There's an emotional labor associated with caring, as a Black person caring for Black people that [white male doctors] just don't have to endure … in their best efforts to be culturally sensitive, they just aren't always, and so being able to exist in a space where not only do you not really understand me, but also sometimes you offended me, and having to navigate that I think is the biggest barrier of just going to work every day."*
> *(33 year old, South, Independent Practice, Urban, Black)*

She continued describing the long-term effects of these experiences and how they impacted her current context and future trajectory. The persistent state of heightened alertness, known as hypervigilance, emerged as a long-term challenge to practicing medicine.

> *"… I have done a lot of work to process those things and recover from those things. But I think they stay with me in the sense that both in the present and looking towards the future, I have an awareness of the environment that we still live in and what that can do … there is definitely a sense of—maybe apprehension is a better word, or hypervigilance. I'm just like, OK, be ready, kind of in terms of recognizing that barriers will exist, and so I need to be prepared to overcome them."*
> *(33 year old, South, Independent Practice, Urban, Black)*

Many physicians discussed that negative stressors occurred prior to their current position. One physician recalled performing similar emotional labor during residency and was apprehensive about reaching out to faculty for social support—fearing that she would be a burden to the other Black women at her clinic.

> *"I was the type of resident that kept my head down, knew what I wanted to do, but didn't complain very much.… Out of the 100-plus faculty members, there were only probably two women that were African American, so I didn't want to add to their minority tax.…"*
> *(39 year old, Midwest, Academic Health Center, Urban, Black)*

This minority tax refers to the additional burdens placed upon minority individuals in an organization to mentor, serve on DEI committees, and represent their community. While examples of intersectionality permeated interviews with URiM participants, the majority of emotional and psychological labor illustrations were consistently rooted in gender. Physicians described these harms as having real and ongoing effects in their current practice and as they considered their future in medicine.

Discussion

This study explored microaggressions experienced by early-career women physicians in the clinical setting. Women physicians experienced biased communications with various staff members, patients, and administrators. These behaviors were manifested through environmental discrimination, impacting physicians' level of emotional labor, and

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psychological safety.[19] This climate contributed to the breakdown of respect for individual personhood, leading to invalidating physicians' positions based on identity. These events can negatively affect the mental and physical health of physicians, in both the present and enduring ways. Similarly, this illustrates the multiple layers of internalized harm and detrimental effects produced by microaggressions and the minority tax. Hypervigilance emerges as a salient factor in understanding how physicians' nervous systems continually process emotional and psychological stress.

These findings underscore not only how deeply embedded microaggressions are for women beginning their careers in family medicine, but also how they begin early and compound over time. We found that women physicians encounter various forms of discrimination from all positions of power, affecting career outcomes, trajectories, and life outside of the clinic. This impacts not only the individual physician but also the organization as a whole. Lack of organizational action to identify, address, and intervene on microaggressions can increase levels of burnout, low self-esteem, shame, and decrease confidence.[20] In turn, this can contribute to negative organizational consequences such as increased turnover rates, lower productivity, higher operational costs, unsatisfactory patient care, difficulty recruiting and retaining talent, and legal implications.[21,22]

Healthcare and academic institutions have increasingly implemented reporting structures for workers to inform leadership of microaggressions and other violations. Despite organizational efforts in educating workers about such mechanisms, incidents are reported at a reduced rate due to lack of confidence in management.[23,24] Organizations should restructure their reporting features to increase communication and trust within their institutions. Strong organizational and leadership support is fundamental to fostering workplace environments that effectively confront the prevalence and impact of microaggressions. The current sociopolitical context has intensified this imperative, as diversity, equity, and inclusion frameworks face heightened systemic institutional resistance—including policy elimination and strategically reframing initiatives. These evolving landscapes amplify both the immediacy and scholarly importance of this research dissemination.

Strengths and Limitations

A notable strength within our study is the focused sampling frame: early-career women physicians who earn less than the average yearly salary and are board-certified Diplomates of the ABFM. The narrowly defined sampling frame enhances its transferability towards similar demographics, though not necessarily generalizable across all medical specialties or career stages. Qualitative research aims for transferability and contextual understanding rather than broader generalizability.[25] While data from this study support understanding the prevalence and impacts of microaggressions, specific questions on microaggressions were not included in the interview protocol. Rather, the themes presented here emerged from the data collected concerning workforce and negotiation prompts. Microaggressions should be explicitly explored in future research, which would also benefit from exploring microaggressions experienced across various administrative positions, such as program directors, chairs, and C-suite executives to better understand their complexities within different clinical environments and practice settings.

Conclusion

We identified three themes in how early-career women physicians experienced microaggressions within the clinical setting: biased communications within the clinical setting, patients invalidating physicians' positions based on appearance, and navigating the emotional and psychological labor of clinical and societal expectations. While these negative experiences are subtle in nature, solutions to address them require direct action and intervention. Given persistent shortages in the family medicine pipeline, ignoring microaggressions threatens not only equity but also the stability of our workforce. Microaggressions—from patients or colleagues—can undermine trust, autonomy, and role clarity in the clinical environment. For physician leaders and educators, this study highlights the need to actively name and interrupt biased comments,[26] support URiM and women colleagues, and ensure safe reporting pathways that protect confidentiality and prevent retaliation. For early-career women physicians, these "background" harms can become deciding factors in career longevity. Preceptors, medical directors, and practice leaders must be equipped to recognize, interrupt, and respond to microaggressions—not only to support individual clinicians but to strengthen organizational culture and the broader primary care mission.

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Conflicts of Interest

Madeline Byrd, Sarah Fleischer, Andrew Bazemore, and Annie Koempel are employees of the American Board of Family Medicine. Melissa K. Filippi and Anam Siddiqi are employees of the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. Andrew Bazemore is also an employee of the Center for Professionalism and Value in Healthcare. Additionally, Melissa K. Filippi is employed by Georgetown University in the Department of Family Medicine.

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