Pacific Journal of Health

Volume 6 | Issue 1 Article 11

2023

Doctor of Physical Therapy students' experience with microaggressions in the clinic: a call to action

Jocelin T. Friedman
University of the Pacific, j_friedman2@u.pacific.edu

Todd E. Davenport
University of the Pacific, tdavenport@pacific.edu

Recommended Citation

Friedman, Jocelin T. and Davenport, Todd E. (2023) "Doctor of Physical Therapy students' experience with microaggressions in the clinic: a call to action," *Pacific Journal of Health*: Vol. 6: Iss. 1, Article 11.
DOI: https://doi.org/10.56031/2576-215X.1017
Available at: https://scholarlycommons.pacific.edu/pjh/vol6/iss1/11

Doctor of Physical Therapy students' experience with microaggressions in the clinic: a call to action

Abstract

As Doctor of Physical Therapy (DPT) students fulfill off-campus clinical experience requirements at healthcare institutions, they are mentored by clinical instructors who are employees of said healthcare institutions. Clinical instructors, patients, or other staff members there may commit microaggressions against physical therapy students with varying subject matters, intentions, and effects on the students. Microaggressions are brief verbal humiliations which may or may not be intentional, but nonetheless convey derogatory slights or insults towards a target group. This article explores DPT students' real-life experiences with microaggressions within the clinical education realm and the challenges a Director of Clinical Education faced in efforts to advocate for students. It also delves into the current literature available on the topic, while identifying gaps in research. It is imperative that Doctor of Physical Therapy academic institutions and researchers gather more information on the experiences of DPT students' experiences with microaggressions and establish corresponding policies so that the prevalence of DPT students' experiences with microaggressions is reduced and the negative effects mitigated.

Keywords

Microaggression, Doctor of Physical Therapy Student, Clinical Education, Clinic

Microaggressions are defined as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults to the target person or group [1]." Microaggressions are not limited to racial topics and can also take the form of microinvalidations or microinsults. Ackerman-Barger describes a Microaggressions Triangle in which a microaggression can be viewed from 3 perspectives (recipient, source, and bystander). In this triangle, there are threats to the reputations of all parties; the recipient possibly being seen as too sensitive, the source as racist (or sexist), and the bystander as cowardly [2].

Microaggressions within the workplace are vague, creating difficulties for reporting or addressing them. For those who do report microaggressions in the workplace, the path forward can be challenging due to a lack of microaggression-related policies at many institutions. When microaggressions occur in the workplace, they can cause the recipient to experience a decrease in work performance, a decrease in sleep quality, and an increase in depressive symptoms [3]. These type of 'put downs' are also pervasive in education, especially in higher education where most of the students and faculty are white and non-minority [4]. It was observed that microaggressions were indeed occurring within Doctor of Physical Therapy (DPT) programs, especially when the students were off campus fulfilling their clinical experiences, which warrants further exploration.

As DPT students are required to complete full-time clinical experience under the direct supervision of licensed physical therapists known as clinical instructors (CI's), they are subject to the various communication or management styles of their CI's, Site Coordinators of Clinical Education, fellow staff members, and patients. CI's are full-time physical therapists at external clinics who are volunteer mentors and supervisors to students during their time at the clinic. As

such, the Director of Clinical Education (DCE) at the DPT program does not have any control over the CI's clinical training, academic background, or mentorship style.

There is emerging literature over the last ten years to evaluate the pervasiveness of DPT students' experiences with microaggressions and to explore the ways in which these students are affected by these situations. There is a critical ethnography specifically about the experiences of DPT students on campus and in the clinic [5] and another that is a cross-sectional survey study of only 6 students regarding the experience of underrepresented minority student physical therapists' experience with microaggressions while in the clinic [6]. There is a clear gap in the current evidence in that there are no primary source articles that specifically explore the experiences of DPT students with microaggressions with strong quantitative or qualitative evidence.

Due to the gap in literature, the use of vignettes is helpful to convey experiences of DPT students and amplify the weight of the microaggressions on their clinical education. These short scenarios can illuminate microaggressions from the viewpoints of the recipient, source, and bystander. The proceeding in-depth examples will help the reader to understand the dynamics of intersectionality in cases of microaggressions. This pilot information may inform decisions about how to approach future larger studies. The following vignettes are based on real interactions in the clinic and demonstrate examples of microaggressions directed towards DPT students. Names have been removed to protect the individuals' identities.

Vignette 1:

A DPT student experienced microaggressions from several patients during her clinical experience regarding her being a woman and of a different religion than most patients or staff.

For example, patients said "How do you expect to find a husband or have kids if you are busy training to be a PT?" or "I always thought people of your religion were evil. You are much nicer than I thought you would be." The student (recipient) did not know how to respond to these comments from the patients (source) and did not report the situation to her CI (bystander) because she did not think there was anything that could be done. The subtle indignities were distracting and were a detriment to the student's self-confidence during the full-time clinical experience. The student felt uncomfortable mentioning her last name to patients, given the chance they might make assumptions about her background.

Discussion:

This is consistent with the results of a 2018 study "Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study [7]." Reasons why students did not report mistreatment included but were not limited to the following reasons: fear of retaliation, perception that mistreatment is built into the culture of medicine, not feeling the incident is important enough to escalate, worry reporting an incident will negatively affect their relationship with their preceptor, and the reporting procedures being too troublesome.

Vignette 2:

A clinical instructor witnessed clinical staff, support staff, and managers commenting on a PT student's physical appearance. Some comments were "he should be a model" or "you (CI) must really enjoy having such an attractive student to work with." The student, CI, and patients were all able to hear their comments. Further, staff refused to call the patient by his name and instead called the student "student" or simply "stu." When the CI reported these incidents to the

department manager and to human resources, the offenders were never directly addressed nor was there any education provided to the staff about the proper treatment of students in the facility.

The student (recipient) never spoke up about this, likely due to being embarrassed, not feeling like he was able to complain since he was an intern, or simply not recognizing a microaggression had occurred. The CI (bystander) did not feel supported by upper management in her attempt to address these microaggressions. That lack of empowerment reduced the likelihood of the CI to report other microaggressions and diminished her perceived ability to create a safe environment for her future students. It was peculiar how little was done by management when this issue was escalated, and the question arose of whether it was due to the nature of it being women objectifying a man versus the more common occurrence of a man objectifying a woman. The CI wondered whether this role reversal contributed to the issue being dismissed by management.

Discussion:

Although it may seem minor, misnaming a person is invalidating and inappropriate in the workplace. Even more, commenting on anybody's physical appearance has no place in a professional setting. It was evident the student heard the comments made by employees (source), which distracted him as he tried to treat patients. "Equity in medication education: Addressing microaggressions and discrimination on the wards" explored the frequency of microaggressions experienced by medical and dental students. The article elaborates that frequent microaggressions were in regard to someone's appearance or racial, ethnic, or gender. Challenges for addressing microaggressions included difficulty recognizing what is a

microaggression while a challenge for addressing discrimination included difficulty recognizing and not knowing what to say or do [8].

Vignette 3:

A DCE was notified there was a CI asking a student to remove her mask during patient care, though current state guidelines called for healthcare providers to always wear masks. When the DCE asked why the CI would advise a student to break with PPE guidelines, the male CI claimed, "she has an attractive face and I think we all would like to see her smile." In this case, the student (recipient) was uncomfortable and did not express concern about the comment because she did not want her CI (source) to fail her. When the DCE (bystander) wanted to address these comments directly with the CI on her behalf, the student begged the DCE not to for the aforementioned reason. Although the DCE wanted to advocate for the student, the path forward was unclear, since there was much risk.

Discussion:

Although this was not blatant sexual harassment in the standard form, it was most definitely a microaggression. In a survey study performed with medical students, 73% of students reporting microaggressions were female students compared to 51% of the male students [9].

Vignette 4:

A student of physical therapy and their CI were both first-generation immigrants from Vietnam. The CI stayed 3 hours late after patient care ended every day to perform multiple spell-checks

and grammar checks of their own documentation and the documentation of the DPT student. Edits were repeated over and over until every comma, semi-colon, and parentheses were in the right place and to the satisfaction of the CI. The student was beginning to get fatigued and had little time at home to prepare for the next day's patients because they were working on minute grammar edits for hours on end every night. When the DCE expressed concern about this to the CI, the CI claimed "I am a Vietnamese immigrant and I must prove my command of the English language is better than everyone else's. It is my job to stay late to prove to everyone else that I am capable even though I am not from here. The student is also an immigrant from Vietnam, so I hold them to that same standard. They should understand we have to work harder than people that are from the United States."

The DCE attempted to explain to the CI that the student should be held to the same standards as any other student from any background. It was challenging for the DCE to educate the CI without being accusatory towards the CI, especially since the DCE did not have training in this type of conflict resolution. There was a fear that the CI would either retaliate by making the student even more uncomfortable or by refusing to accept further students from the university. The solution in this case was to have the student finish his clinical experience under the supervision of a different CI at the same clinic.

Discussion:

Although this comment was not meant to demean the student (recipient), it showed implicit bias based on the student's ethnicity. The CI (source) made assumptions about the student based on his background and treated him differently than other students which caused the student great

stress. Although perpetrated by someone of the same ethnicity, it was a microaggression, nonetheless. The student did express feeling anxious, which echoes the reports of authors Ackerman-Barger and Jacobs, claiming "microaggressions have been shown to have a dose-response relationship with depression and anxiety [2]." This situation also made the DCE (bystander) realize that the standard DEI training for faculty may not be sufficient to handle situations when the students experience microaggressions off-campus.

Call to Action:

An unfortunate truth is that the "micro" in microaggressions can often make others feel incredulous about the "smallness" of the pain they inflect on their victims - that because they do not rise to the level of overt sexual harassment or blatant racism, they can be managed personally, stoically, and without the need for intervention. But, as shown in the vignettes, microaggressions can significantly impact their recipients, and, if they are not addressed, can create hostile and non-productive learning environments for DPT students.

The challenging role of the DCE advocating for the student while they are in the clinic is made even more challenging because CI's are not affiliated with the university and are not direct reports of the DCE. The DCE cannot directly control the behaviors of the CI, staff, or patients at the facility towards the students. Although a DCE may give feedback to CI's, they must tread lightly out of concern that bringing attention to issues may make the student feel more uncomfortable or become the subject of retribution. Students displayed various levels of distress and resiliency from these experiences. There was a trend in these situations in which the DCE noticed the students were hesitant to discuss the microaggressions with the DCE, like in vignettes one and two. Even when they were comfortable discussing them (at the DCE's

encouragement), the students did not want the DCE to address them with the CI's out of fear of retaliation by the CI. What was most notable, was that these were just experiences brought to the DCE's attention due to co-occurring issues warranting her involvement. The author had no idea how many other students were experiencing microaggressions, how these microaggressions were affecting the students' ability to learn, and how these microaggressions could be affecting their mental health. One possible solution would be for the DPT department to educate students about how to recognize microaggressions before they enter the clinic, so they are better prepared. On the faculty end, the DCE can be more proactive and talk to their students about microaggressions, while establishing a safe space for students to bring concerns forward throughout their experiences. Students and faculty could potentially participate in training sessions about microaggressions and debrief after clinical experiences to discuss students' experiences. These types of changes would need to be supported at a departmental and university level.

The CI's role main role is to provide clinical guidance while the DCE is in more of a supportive role, often from a distance. The DCE can visit clinics in person and use phone or zoom calls to intervene and support the students, though conversations can be precarious. In the preceding scenarios, the DCE was unclear how to facilitate these challenging conversations with the students and CI's, despite a desire to advocate for the students. As evidenced in vignettes 3 and 4, the DCE intended to support their student by approaching the CI, though the conversations were challenging and the DCE did not have much support from the DPT department. Although faculty receive diversity, equity, and inclusion (DEI) training, the training emphasized equitable treatments of faculty peers and of students in on-campus settings. There was not any training for clinical education faculty on how to educate students and external

clinical partners about microaggressions, how to prevent microaggressions, or how to handle situations in which students experience microaggressions while in the clinic. Furthermore, there weren't any standard operating procedures for when these situations arise. The DCE may need to collaborate with departmental leadership as well as partner with DEI committees within larger universities to establish standard operating procedures for when a microaggressions is committed against the student in the clinic. There needs to be a policy written about how and when a DCE should attempt to educate the committing CI and when the DCE should remove the student from that clinical site entirely. The DCE may jump start this initiative, though will need the support of higher leadership to get policies added to faculty or student handbooks.

The American Physical Therapy Association (APTA) has a standing DEI committee committed to "increasing diversity, equity, and inclusion in the association, profession, and society [10]." The accrediting body has policies surrounding a DPT program's recruitment and admission guidelines "designed to enhance diversity of the student body", though there aren't any requirements for DEI training of students, faculty, or external clinical partners [11]. Despite both bodies emphasizing the importance of DEI, there are not established guidelines for facilitating and maintaining inclusive environments for student physical therapists while in the clinic. One way the APTA could be more proactive about preventing CI's from committing microaggressions against students would be to incorporate more DEI and microaggression-related content to the universally taught Credentialed Clinical Instructor Program. On the other end, CAPTE could mandate microaggression-related competencies for students and faculty alike.

The commonality between the situations explored in the vignettes, is that students are at risk for microaggressions while in the clinic and that the DCE is eager to advocate for them, though they lack the knowledge and resources in which to do so. There is a dearth of evidence-

based research on the topic, training for students or faculty, and a lack of practice guidelines about how to address microaggressions once they happen to students in the clinic. Even more, there are no consistently used mechanisms in which to measure the occurrence of microaggressions or ways in which to ensure accountability to CI's, students, and DCE when it comes to maintaining a safe environment for DPT students.

Current structures in both the clinical and academic settings create power imbalances for DPT students which allows for an environment where microaggressions are more common and possibly less likely to be dealt with. The preceding vignettes and identified gaps in research about DPT students' experiences with microaggressions show there is more to understand and more to be done to advocate for DPT students who are most vulnerable in the clinic. Ultimately, if DPT programs are to continue to send their students into clinics under the mentorship of external partners, more needs to be done to reduce the occurrence of and mitigate negative effects of microaggressions as experienced by students.

References

[1] Gilliam, C., & Russell, C. J. (2021). Impact of racial microaggressions in the clinical learning environment and review of best practices to support learners. Current Problems in Pediatric and Adolescent Health Care, 51(10). https://doi.org/10.1016/j.cppeds.2021.101090

[2] Ackerman-Barger K, Jacobs NN. The Microaggressions Triangle Model: a humanistic approach to navigating microaggressions in health professions schools. *Acad Med.* 2020;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S28-S32. doi:10.1097/ACM.0000000000003692

[3] Fattoracci, E. S., & King, D. D. (2022). The need for understanding and addressing microaggressions in the workplace. *Perspectives on Psychological Science*, *18*(4), 738–742. https://doi.org/10.1177/17456916221133825

[4] Ogunyemi, D., Clare, C., Astudillo, Y. M., Marseille, M., Manu, E., & Kim, S. (2020). Microaggressions in the learning environment: A systematic review. *Journal of Diversity in Higher Education*, *13*(2), 97–119. https://doi.org/10.1037/dhe0000107

[5] Turner, C. (2021). *EXAMINING THE EXPERIENCES of LGBTQ DPT STUDENTS: A CRITICAL ETHNOGRAPHY* (Publication No. 28542030) [Doctoral Dissertation, University of Nevada, Las Vegas]. PsychInfo. https://doi.org/10.34917/25374114

[6] Steinkamp, L. (2021). Microaggressions: underrepresented minority physical therapist student experiences while on clinical internships. WMJ: Official Publication of the State Medical Society of Wisconsin, 120. https://www.ncbi.nlm.nih.gov/pubmed/33819406

[7] Chung, M., Thang, C., Vermillion, M., Fried, J. M., & Uijtdehaage, S. (2018). Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study. Medical Education Online, 23 (1), 1478170. https://pubmed.ncbi.nlm.nih.gov/29848223

[8] Sandoval, R. S., Dunleavy, S., Afolabi, T., Said, J. T., Connor, J., Hossain, A., Kassamali, B., Kienka, T., Srinivasan, M., Cheng, A., Ölveczky, D., & Chatterjee, A. (2021). Equity in medical education: Addressing microaggressions and discrimination on the wards. *Medical Teacher*, *44*(5), 551–558. https://doi.org/10.1080/0142159x.2021.2006617

[9] Espaillat, A., Panna, D. K., Goede, D. L., Gurka, M. J., Novak, M. A., & Zaidi, Z. (2019). An exploratory study on microaggressions in medical school: What are they and why should we care? *Perspectives on Medical Education*, *8*(3), 143–151. https://doi.org/10.1007/s40037-019-0516-3

[10] APTA Diversity, Equity, and Inclusion Action Plan. (2023, July 5). APTA. https://www.apta.org/apta-and-you/diversity-equity-and-inclusion/dei-action-plan

[11] Commission on Accreditation in Physical Therapy Education. (2020, November 3). *STANDARDS AND REQUIRED ELEMENTS FOR ACCREDITATION OF PHYSICAL THERAPIST EDUCATION PROGRAMS.* Accreditation Handbook. Retrieved March 12, 2023, from https://www.capteonline.org/about-capte/resource_documents/accreditation-handbook