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Addressing Bias in SLP Problem-Based Tutorials through Critical Reflexivity, Curriculum Development and Instructor Training

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Abstract

Racism is prevalent in the fields of healthcare and education in North America and speech-language pathology and audiology are no exception. Systemic and individual racism in educational, training, and clinical settings creates barriers for student entry and success, and negatively impacts client care. Although the ability to serve clients of diverse backgrounds is a crucial skill for students and clinicians, current educational curricula appears insufficient in supporting culturally diverse students and preparing all students to work with culturally diverse populations. This is, in part, due to a lack of diverse representation in education and clinical settings, bias experienced by SLP and audiology students in education programs, and problematic ways in which clinical information and race are presented in these educational programs. This paper aims to provide evidence informed guidance to SLP and audiology educators that will support their efforts to: 1. Develop students' critical reflection and critical reflexivity skills. 2. Integrate racial and cultural diversity in the curricula. 3. Develop instructor competencies to create a safe learning environment. An example of a problem-based tutorial course in an SLP program is presented with a focus on clinical case development and small group learning experiences. Revision of curricula content with a focus on developing students' lifelong skills in critical reflexivity may provide a foundation to equip SLPs and audiologists to address existing health disparities and improve client outcomes.

Keywords

curriculum, problem-based learning, bias, training, speech-language pathology

Cover Page Footnote

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Structural inequalities, such a racism, classism, and ableism, affect health inequalities and can inform the training needs and educational experiences of health care providers (Nixon, 2019). The Anti-Racism Advocacy Group for Speech-Language Pathology (SLP) and Audiology (ARAGSLPA, 2020) in Quebec, Canada illustrate that racism exists in SLP training programs and clinical environments, negatively affecting students, faculty, clinicians, and clients. The call to action by Ellis and Kendall (2020) and Kendall (2020) highlight that individual and systemic racism and oppression are also prevalent in the fields of Communication Sciences and Disorders (CSD) in the United States of America, impacting education and service. Pervasive racism in these fields, including microaggressions and institutional discrimination, experienced in academic and clinical settings creates barriers for students of color to gain entry and success in SLP and Audiology programs (ARAGSLPA, 2020; Davis, 2020; Ellis & Kendall, 2020; Ginsberg, 2018; Loya & Uomoto, 2016; Mayes et al., 2020) and contributes to feelings of isolation and lack of success in higher education (Davis, 2020; Ginsberg, 2018; Hubain et al., 2016; Mayes et al., 2020). As such, there is an underrepresentation of Black, Indigenous, and people of color among CSD students, faculty, and clinicians despite a diversity in clients served across Canada and the United States; and these individuals may encounter both microaggressions and institutional racism in their training and clinical environments (American Speech Language Hearing Association [ASHA], 2024; ARAGSLPA, 2020; Ellis & Kendall, 2020).

Microaggressions are defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of colour" (Sue et al., 2007, p. 271). Microaggressions are prevalent in education and health settings; for example, students of color may be told they speak good English and may be asked where they are from, even if they were born within the country. This creates feelings of "othering" and perpetual foreigner status and negates the students' heritage (Abdelaziz et al., 2021; Sue et al., 2007). Healthcare students, including SLP students in North America, report experiencing microaggressions from peers, faculty, preceptors, and via the curriculum (Abdelaziz et al., 2021; Ackerman-Barger et al., 2020; ARAGSLPA, 2020; Davis, 2020; Ellis & Kendall, 2020; Ginsberg, 2018; Mayes et al., 2020), leading students to feel alone and devalued, and impacting academic and overall wellbeing (Ackerman-Barger et al., 2020; Davis, 2020; Ginsberg, 2018; Hubain et al., 2016; Mayes et al., 2020). Students and therapists who are not trained to recognize their own biases and microaggressions may bring these into their clinical settings, negatively affecting their relationship and quality of care with clients (Sue et al., 2007).

Institutional racism is also present in the policies, practices, and actions embedded in education settings, which marginalize, oppress, and disadvantage racialized individuals resulting in barriers to academic entry and success, decreased wellbeing, and inequitable life outcomes (Henry & Tator, 2009; Merolla & Jackson, 2019 Pilkington, 2013). Structural racism is present in both health and education institutions and has been defined as "a social system in which race is a central principle of social organization that serves to sort individuals into positions of relative advantage and disadvantage based on their racial category" (Merolla & Jackson, 2019, p. 2). In SLP and Audiology programs institutional barriers may decrease access for culturally and linguistically diverse students, such as an emphasis on grade point average (GPA) and financial expectations (e.g., tuition and living expenses; Mohapatra & Mohan, 2021) and a lack of exposure to or being counselled away from the profession (Abdelaziz et al., 2021; Richburg, 2022; Suswaram et al.,

2022). In clinical settings, institutional racism negatively impacts clients' access to and quality of care, as well as clinician-client relationships (ARAGSLPA, 2020; Feagin & Bennefield, 2014; Elias & Paradies, 2021; Loya & Uomoto, 2016). For example, some immigrant families may have a lower income that compromises their ability to attend appointments due to time needed off from work, proximity to quality health care providers, and the costs of transportation and services; however, nonattendance may be interpreted as a lack of motivation among newcomers to the country (ARAGSLPA, 2020). A lack of awareness, training, and skills in intercultural practice can lead to biases in clinical decision making and negative clinical outcomes (ARAGSLPA, 2020; Ellis & Kendall, 2020; Loya & Uomoto, 2016). Institutional racism can result in distrust of the healthcare system, underutilization of healthcare resources, premature termination of services, and poor health outcomes; therefore, it is necessary to train students to identify and confront institutional racism (Elias & Paradies, 2021; Sue et al., 2007).

As such, it is important that culturally diverse clients are well supported, and that students and clinicians have the knowledge and skills to work with culturally diverse populations. The ability to serve diverse populations is recognized as an essential skill and standard of practice in speech-language-hearing professions (ASHA, 2024; College of Audiologists and Speech-Language Pathologists of Ontario [CASLPO], 2022). For example, regulatory colleges in the United States and Canada list best practices for serving diverse populations, including addressing one's own conscious and unconscious beliefs and implementing practices that actively embody, accept, and respect diversity in all aspects of intervention (ASHA, 2024; CASLPO, 2022. These skills can be cultivated through the practice of cultural humility, "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in healthcare, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123).

Unfortunately, research indicates that current curricula and training in healthcare fields appear insufficient in preparing clinicians to provide services to diverse populations (Krishnan, 2019; Mayes, 2020). The ways in which information regarding race and culture are currently presented in healthcare education curricula often implicitly uphold systems of oppression and marginalization (Krishnan, 2019; Nieblas-Bedolla et al., 2020; Tsai et al., 2016). Krishnan and colleagues (2019) noted that in medical clinical cases when race is explicitly stated, the patient is almost always a person of color, which may imply that white is the default patient identity, thereby marginalizing students and patients of color. Additionally, race is often presented in lectures without context or justification (Tsai et al., 2016) and is inaccurately represented as a biological rather than social risk factor for diseases and health disparities (Krishnan, 2019; Nieblas-Bedolla et al., 2020; Tsai et al., 2016). Students from various health professions, including speech-language-hearing professions, provided suggestions for promoting inclusion in curricula reform, including a greater focus on social determinants of health and health inequity, and opportunities for open conversations on race, ethnicity, and racism (Ackerman-Barger et al., 2020; Davis, 2020; Ginsberg, 2018; Mayes et al., 2020). Indeed, Ebert (2013) found that SLP and Audiology students demonstrated minimal awareness of racial privileges in these fields.

In summary, CSD graduate programs must prepare graduates to work with clients of diverse backgrounds by equipping them with the knowledge and skills necessary for cultural sensitivity and humility. Bias experienced by CSD students of color, however, and the ways in which clinical

information and race are presented in educational programs, are problematic. Addressing how clinical information and race are presented in CSD academic programs can enable space for discussion and exploration of institutional and individual racism and biases, and help better equip students with knowledge and skills to work with clients of diverse backgrounds.

Therefore, this paper is needed to provide evidence informed guidance for how race and other aspects of diversity (e.g., language, sexuality, gender, neurodiversity) can be integrated into SLP curricula, with a focus on clinical case development and small group learning experiences. The aim was to provide evidence informed guidance to SLP and audiology educators that will support their efforts to: (a) develop students' critical reflection and critical reflexivity skills, (b) integrate racial and cultural diversity in the curricula, and (c) develop instructor competencies to create a safe learning environment. Literature pertaining to these three areas is summarized below, then applied to a problem-based tutorial course in a SLP program at McMaster University in Ontario, Canada.

Develop Students' Critical Reflection and Critical Reflexivity Skills

Critical reflection and critical reflexivity are important professional competencies that can lead to individual and systemic changes in healthcare settings by fostering cultural sensitivity and humility (Ng et al., 2019). Ng et al. define critical reflection as "the process of examining assumptions, such as individual and societal beliefs, values, and power relations, and how these assumptions and relations shape practice" (2019, p. 1122-1123). They provide a related definition of critical reflexivity as "recognizing one's own position in the world both to better understand the limitations of one's own knowing and to better appreciate the social realities of others" (Ng et al., 2019, p. 1124). For example, students may contrast their perspective and relative power as a postsecondary trained clinician who has strong literacy skills with a potential client who has low literacy skills. They may consider the impact of communication, literacy and power on access to service and information, when clinical registration uses a complex e-portal, or assessment findings and recommendations are shared via a written report.

Critically reflective practitioners challenge and change their assumptions and practices when they notice potential harms, work to mitigate negative outcomes, and reshape perspectives and power structures (Ng et al., 2019). To alleviate negative influences of bias on clinical outcomes, programs should focus on increasing students' knowledge of implicit biases, their influence on behaviours and client outcomes, and ways to mitigate the negative impacts of these biases (Dogra et al., 2016; Stone & Moskowitz, 2011; Stowe, 2020; Sukhera & Watling, 2018). This knowledge is important as, unlike explicit biases, which are more easily recognized and controlled, individuals are often unaware of their own implicit biases (Dovidio et al., 2002). However, both types of biases impact marginalized individuals and can alter the clinician-client relationship in perceptible ways (Stone & Moskowitz, 2011).

To become critically reflexive practitioners, students must be aware of how institutions can contribute positively and negatively to patient experiences and health outcomes (Dogra et al., 2016). Additionally, understanding the systems of privilege and oppression and one's own social positioning is an important first step (Nixon, 2019; Ng et al., 2019). Critical reflection of one's own implicit biases and the resulting client impact in a supported learning environment can allow

students to explore their biases (Appert et al., 2018; Dogra et al., 2016; Nieblas-Bedolla et al., 2020; Sukhera & Watling, 2018) and also be used as a teaching and learning tool, allowing students to track progress over time (Brottman et al., 2020). Research by Brottman and colleagues found that reflection had a positive influence on students' cultural knowledge, awareness, and skills (2020).

Integrate Racial and Cultural Diversity in the Curricula

In order to integrate racial and cultural diversity information into the curricula, coursework should incorporate issues of race, racism, privilege, marginalization, social burden of disease, and implicit biases in healthcare, as well as their impacts on clinical decision making and client outcomes (Ellis & Kendall, 2020; Nixon, 2019; Sukhera & Watling, 2018). This information should be introduced early and continue as an ongoing component of the curriculum, revisiting and building on prior concepts to enhance knowledge (Beavis et al., 2015; Davis, 2020; Dogra et al., 2005; Dogra et al., 2016). Societal power structures and how they influence health inequities are also important considerations given the negative impact of institutional and structural racism on healthcare outcomes (Beavis et al., 2015; Ellis & Kendall, 2020; Nixon, 2019).

Furthermore, instructors should select course content that represents diversity and diverse perspectives of clients and clinicians (Appert et al., 2018; Sanger, 2020) with awareness that biases and stereotypes may unintentionally be reinforced in portrayal of diverse populations and, therefore, take steps to mitigate this bias (Sukhera & Watling, 2018). For example, if negative outcomes are only assigned to people of color in clinical cases, students may internalize reductionist views of people of color and associated implicit biases (Krishnan et al., 2019). Healthcare problems (HCPs) that promote the application of theory to practice in exploring concepts of liberation, justice, and ethical practice are recommended (Privette, 2023). Such HCPs might focus on a classroom environment where a teacher refers every child who is multilingual for a SLP assessment, stating concerns about their literacy skills due to use of "non-academic" language (Privette, 2023), or students could explore multiple aspects of a challenging problem if the HCP focused on a SLP who was thoughtfully considering whether to expand their practice to include accent modification (Yu et al., 2022).

Develop Instructor Competencies to Create a Safe Learning Environment

Successful implementation of content and curricula on cultural sensitivity and humility begins with those delivering it (Brottman, 2020; Lipson & DeSantis, 2007; Romanello, 2007). As such, instructors should critically reflect on their own values and beliefs, and be able to communicate effectively while conveying empathy to all individuals regardless of their race or ethnicity (Hordijk et al., 2019). Instructors should convey the same level of confidence in the abilities of all their students, which are teaching practices supported by culturally responsive principles (Appert et al., 2018; Day & Beard, 2019; Sukhera & Watling, 2018). Furthermore, using culturally responsive teaching principles, such as asking questions to challenge student assumptions and facilitating discussions, can provide students with opportunities to learn from others and reflect on their own beliefs (Day & Beard, 2019).

Teaching and facilitating conversations on race, power, privilege, and their impacts on health outcomes can be challenging. Wagner (2005) argues that instructors need to anticipate and affirm strong emotions that may arise when discussing these topics, and address conflicts and difficult discussions head-on rather than avoiding them. Establishing a class climate conducive to these conversations is crucial (Wagner, 2005). Instructors should acknowledge that students come with a multitude of diverse experiences and perspectives which necessitate collaborative work with students to establish a collective understanding of classroom expectations and an adequate degree of safety to participate in learning and discussions (Sukhera & Watling, 2018; Wagner, 2005). Setting explicit expectations for students as well as openly addressing the discomfort that accompanies discussions of bias and privilege are inclusive teaching practices supported by research (Appert et al., 2018; Sanger, 2020; Stowe, 2020; Sukhera & Watling, 2018). Acknowledging power imbalances between instructors and students, and between different healthcare professionals, and one's own social positioning can help to create learning environments that support a climate of safety (Ross, 2014; Sanger, 2020; Sukhera & Watling, 2018; Wagner, 2005). Brottman and colleagues (2020) found that smaller groups allowed for a safer environment, and enhanced self-reflection from students. The importance of safe learning environments is often discussed; however, Ng (1995) contends that safety has never been a reality for people of color in mainstream Eurocentric systems such as academia. bell hooks (1994) stated, "Rather than focusing on issues of safety, I think that a feeling of community creates a sense that there is a shared commitment and a common good that binds us. What we all ideally share is the desire to learn..." (p. 40).

Application of Critical Reflection, Curriculum Development, and Instructor Competencies in Problem-Based Tutorials

Problem based tutorials (PBT) represent a unique way to address and discuss the themes above in the context of an academic setting. Learning in PBT is constructed around HCPs and guided by tutors who have experience in the field (Whitehill et al., 2014). In PBT, students examine an HCP in small groups and identify areas for further learning and exploration. Learning objectives are created around these areas for further learning and students conduct individual research before returning to the small group setting to share their information (Whitehill et al., 2014). PBT allows students to apply their learning to "real life" clients by exploring HCPs in a self-directed manner, while drawing on evidence-based practice. Given the small group and self-directed yet guided nature of PBT, HCPs can provide opportunities for students and tutors to practice critical reflection and reflexivity while integrating and exploring diverse client characteristics and perspectives in the context of "real life" clinical scenarios. Furthermore, the structure of PBT and its guided learning approach lends itself well to the "teacher as facilitator" principle of culturally relevant pedagogy which has also been discussed in nursing education curriculum (Day & Beard, 2019). Therefore, this project team comprised of students and faculty from the McMaster University SLP program in Ontario, Canada decided to address the three areas discussed above in a PBT course by:

- developing students' critical reflection and critical reflexivity skills during PBT discussions;
- integrating racial and cultural diversity in PBT HCPs; and
- developing and providing training to improve tutors' competencies to facilitate reflexive discussions about diversity in a safe group learning environment.

In practice, these themes were intertwined; for example, the development of diverse HCPs prompted richer discussion and reflection among students and the tutors were better prepared to facilitate these discussions due to their additional training. The tools developed by the project team to critically reflect on and improve the diversity in the HCPs will be presented below alongside the use of these tools in the McMaster University SLP program. Instructor training and implementation is described.

Two tools were developed by the project team to promote critical reflection on the racial and cultural diversity presented in the HCPs: (a) a Case Development Diversity Checklist to be used by course instructors when creating and revising HCPs (Figure 1), and (b) Client Demographic Forms to be included with each HCP (Figure 2). To develop the checklist, main points from the literature summary were discussed amongst the authors, organized into broad statements and associated questions, and split into three categories: case study development, learning objective development, and ongoing reflection and safety. The questions provide considerations for course instructors to apply when creating and revising the HCPs. Items were worded in similar ways such that the answers to the questions would be "yes" if the HCP met the diversity criteria. If the answer to a question was "no", the HCP was revised. This checklist was used by one course instructor and additional members of the study team to review and revise the HCPs for one PBT course. This process allowed the team to revise the tool.

Some HCPs had specific learning objectives related to diversity and inclusion; the goal for many, however, was for students to holistically consider information on race, culture, and linguistic diversity among other factors when applying literature to the HCP to plan assessment, treatment, and client communications. To facilitate this, Client Demographic Forms were created to help depict each client holistically, portray diversity in client populations, and provide some general information that may be received during an initial intake (e.g., race, age, languages). Although these forms are often present in clinical environments, they had not been consistently provided with HCPs to allow students to integrate identity factors into their approach to clinical cases. Two forms were created, one for children that included information about parents (Figure 2) and another for older clients. The Client Demographic Forms were first created with the authors brainstorming general information that would be received during an initial intake in their clinical practices, then designing the form with consideration for wording and organization. There were concerns amongst the authors that providing the information in the Client Demographic Forms would pose additional challenges for students when generating learning objectives from the cases, in that students would be inclined to create separate learning objectives for specific client identity factors rather than integrating them into their assessment, treatment, and communication plans. Solutions to this challenge included applying the demographic forms for all HCP clients and providing explicit instructions for students and tutors. Additionally, for some HCPs, probing questions were added for tutors to encourage students to consider how a client's and SLP's identity and social positioning may impact assessment, treatment, and communication. Students were encouraged to consider information from the demographic form when critiquing the pertinent research literature, planning assessments, formulating goals and treatment plans, and/or planning how they might communicate with clients and family members in the HCP. Students were invited to provide feedback about the HCPs and demographic form via an electronic survey. Overall, students provided positive

feedback about these materials and tutors reported that they prompted rich consideration of culturally sensitive assessment and intervention.

Figure 1

Case Development Diversity Checklist to be Used by the Course Instructor When Creating, Reviewing, or Revising a Case

Case Development Diversity Checklist
Case Study Development (Criteria 1-3)
1. Complete the Client Demographic Form simultaneously with the HCP. (Anker, 2007; Appert et al., 2018; Finucane, 2014; Jacobs School of Medicine University of Buffalo, 2020; Northwestern University Feingberg School of Medicine, n.d.) 1.1. Does the client information include the following sections: Full name, Age, Sex, Gender, Language capabilities, Race, Ethnicity, Health history, Health condition (diagnosis), Hearing and vision status, Educational background, Vocation, Who lives in the home, and Religion/Spirituality? 1.2. Do the set of HCPs culturally represent the backgrounds of clients and families we serve (e.g., including culturally influenced names and environmental factors) in non-stereotypical ways? 1.3. Is the language and wording respectful of the people portrayed and in alignment with inclusive language recommendations? 1.3.1 Do the statements refrain from encouraging any stereotypes, bias, shame, and stigma? (e.g., avoid stating or implying that all clients from a particular culture participate in certain practices or reject certain medical interventions; avoid presenting associations between race and disease incidence without context). 1.3.2 Do the statements regarding health behavior describe the client (e.g., client with a substance use disorder) rather than define the client (e.g., client was a drug addict)? 1.4. Is the information included in the case that would provide an opportunity for students to demonstrate compassion and cultural sensitivity? (e.g., a client disagreeing with initial treatment plan; a client describing how they prefer to be addressed (e.g., pronunciation of name, title, pronouns)).
2. Be cognizant of implicit curricula influences that may lead students to internalize and perpetuate patterns of behaviour/stereotypes, etc. (Ackerman-Barger et al., 2020; Jacobs School of Medicine University of Buffalo, n.d.; Northwestern University Feingberg School of Medicine, n.d.). 2.1. Is the HCP that incorporates marginalized groups presented in a positive light as opposed to a negative light/associated with many barriers? 2.2. Are both White people and people of color impacted by social determinants of health across cases? 2.3. Are genetically/biologically determined diseases distinguished between those determined by social determinants of health?
3. Select course content that recognizes diversity and acknowledges barriers to inclusion. (Appert et al, 2018). 3.1. Does supplementary content engage a diversity of ideas and perspectives? 3.2. If possible, is supplementary content elicited from authors of diverse backgrounds? 3.3. Select course content that centres the experience and knowledge of people who are represented by the case.

Figure 1 (continued)

Learning Objective Development (Criteria 4-5)
4. Establishing learning objectives relating to diversity and inclusion. (American Academy of Family Physicians, 2024; Baba, 2013; Ross, 2014; Sukhera & Watling, 2018; Wagner, 2005) 4.1. Are the practical skills or knowledge that students are expected to attain relating to diversity and inclusion clearly outlined to tutors and students? - For example: Learners will make connections between social determinants of health and the relevance to clinical assessment and intervention.
5. Include diversity curricula/studies throughout/across entire program. (American Academy of Family Physicians, 2024; Beavis et al., 2015; Dogra et al., 2016; Durey, 2010; Hordijk et al., 2019; Jacobs School of Medicine, 2020; Ross et al., 2014; Solotke et al., 2019; Sukhera & Watling, 2018). 5.1. Are these learning objectives linked to learning outcomes or course content in concurrent or previous courses? Has the course coordinator consulted with other instructors? 5.2. Do students have a solid foundation/understanding of bias and its role in healthcare to engage in discussions on this topic? 5.3. Do students have a solid foundation/understanding of ethnic and social determinants of physical and mental health (e.g. risk factors, unfamiliar diseases, epidemiology) and barriers to healthcare relevant in Canada?
Ongoing Reflection and Safety (Criteria 6-7)
6. Encourage self-reflection. (Appert et al., 2018; Beavis et al., 2015; Dogra et al., 2015; Durey, 2010; Hordijk et al., 2019; Ross, 2014; Sukhera & Watling, 2018). 6.1. Do the learning objectives and/or probing questions encourage self-reflection of beliefs and biases? 6.2. Do the learning objectives and/or probing questions encourage self-reflection of how one's own experiences of privilege and oppression affect their practice?
7. Encourage a safe learning environment. (ARAGSLPA, 2020; Durey, 2010; Equity and Inclusion Office McMaster University, 2020; Roberts, 2020; Sukhera & Watling, 2018; Wagner, 2005). 7.1. Is the HCP set up to ensure adequate time to discuss learning objectives so that students do not feel rushed? 7.2. Do tutors feel prepared to openly address the discomfort that may come from conversations of bias and privilege (for both tutors and students)? 7.3. Does the PBT coordinator/tutors feel they have the knowledge and skills to facilitate the safe learning environment (previously discussed within group)?

Instructor Training

In the McMaster University SLP program, the PBT course includes a course instructor who is responsible for student evaluation, as well as providing training and support to the PBT tutors. The PBT tutors work directly with students and are typically practicing community SLPs who are paid for this role. The project team developed a resource package to support tutors' confidence and ability to create safe learning spaces in which students can critically explore topics related to diversity and justice. The resource package included a self-guided and a synchronous training session with learning activities, practical tips, and reflection questions to guide tutors in understanding and reflecting on systemic and individual bias, privilege, social positioning, intersectionality, and their impacts on education and healthcare settings. This package prompted

reflection on ways to cultivating a safe learning environments and allowed tutors a supported opportunity to interrogate their own biases and work through case-based scenarios that could occur in PBT as related to bias and discrimination. Specific strategies to promote power sharing were recommended and implemented including: encouraging students and tutors to share a personal piece of information about themselves during introductions (e.g., their favorite summer activity or ice cream flavor), using first names for tutors, having the tutor share their goals and request feedback from the students, and being explicit that students could book time with the course coordinator if challenging situations arose that they wanted to discuss without peers or the tutor present. Tutors were engaged during the training session, and it will be repeated with future cohorts. Self-guided learning options included suggested resources, learning objectives for tutors, and guiding questions that could be completed independently at one's own pace in alignment with their skillset and personal goals. Future work may include providing tutors and students with support to explicitly consider power dynamics and cultural considerations in their peer, self, and student evaluations.

Figure 2

Client Demographic Form for Children and Caregivers

Child Client/Family Demographic Information	
Full name	
Age	
Sex assigned at birth	
Gender (and pronouns)	
Language capabilities	***E.g., "English (understands, speaks, reads); French (understands, speaks)"***
Race and ethnicity	
Health history	
Health condition (diagnosis)	
Hearing and vision status	
Educational status	**Grade:** ***e.g., "Grade 6 (life skills classroom)"***
Religion/spirituality	
Who lives in the home? (please specify relationship)	
Caregiver - highest level of education	
Caregiver - vocation	
Other	

Call to Action

It is clear from the literature that racism, both systemic and individual, has far-reaching negative impacts on students, clinicians, and clients. To begin addressing this, instructors are encouraged to use the Case Development Diversity Checklist and Client Demographic Forms to review and revise case studies used in any of their courses to ensure diversity is reflected without bias. Instructors are also encouraged to revise curricula content to include information about diversity, biases, and the potential for inequity in care and differential outcomes. This will promote the acquisition of skills that require lifelong commitment and re-examination of beliefs and biases, such as critical reflection, reflexivity, and cultural humility. These steps may aid in efforts to meet the equity, diversity, and inclusion goals set forth by professional bodies such as the American Speech-Language-Hearing Association (ASHA) in their Public Policy Agenda (ASHA, 2023) and CASLPO in their Statement on Anti-Racism and the Provision of Ethical Care (CASLPO, 2020). Tangible resources and actions are needed to advance these statements beyond words and into changes that will better equip future SLPs and Audiologists to provide responsive services to culturally and linguistically diverse populations and advance health equity.

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References

Abdelaziz, M. M., Matthews, J. J., Campos, I., Fannin, D. K., Rivera Perez, J. F., Wilhite, M., & Williams, R. M. (2021). Student stories: Microaggressions in Communication Sciences and Disorders. *American Journal Speech Language Pathology, 30*(5), 1990-2002.https://doi.org/10.1044/2021_AJSLP-21-00030

Ackerman-Barger, K., Boatright, D., Gonzalez-Colaso, R., Orozco, R., & Latimore, D. (2020). Seeking inclusion excellence: Understanding racial microaggressions as experienced by underrepresented medical and nursing students. *Academic Medicine, 95*(5), 758. https://doi.org/10.1097/ACM.0000000000003077

Anker, G. M. (2007). *Clinical decision making: Case studies in medical-surgical nursing*. (2nd ed.). Delmar Publishers Inc.

Anti-Racism Advocacy Group for Speech-Language Pathology and Audiology (ARAGSLPA). (2020). *Report on the impacts of systemic racism in speech-language pathology and audiology professions in Quebec*. https://www.gaaroa.ca/publications?lang=en

American Academy of Family Physicians. (2024). *Implicit bias resources.* https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html

American Speech Language Hearing Association (2024). *Cultural responsiveness*. https://www.asha.org/practice-portal/professional-issues/cultural-responsiveness/

American Speech Language Hearing Association (2023). *Public policy agenda.* https://www.asha.org/advocacy/2023-asha-public-policy-agenda/

Appert, L., Jungels, A. M., Bean, C. S., Klaf, S., Irvin, A., & Phillipson, M. (2018). *Guide for inclusive teaching at Columbia.* Columbia Centre for Teaching and Learning. https://ctl.columbia.edu/resources-and-technology/resources/inclusive-teaching-guide/download/

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Metis Public Health: Environmental scan of cultural competency and safety in education, training and health services.* National Collaborating Centre for Aboriginal Health. https://www.ccnsa-nccah.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf

Beavis, A. S., Hojjati, A., Kassam, A., Choudhury, D., Fraser, M., Masching, R., & Nixon, S. A. (2015). What all students in healthcare training programs should learn to increase health equity: Perspectives on postcolonialism and the health of Aboriginal Peoples in Canada. *BMC Medical Education, 15*(1), 1-11. https://doi.org/10.1186/s12909-015-0442-y

Brottman, M. R., Char, D. M., Hattori, R. A., Heeb, R., & Taff, S. D. (2020). Toward cultural competency in health care: A scoping review of the diversity and inclusion education literature. *Academic Medicine, 95*(5), 803-813. https://doi.org/10.1097/ACM.0000000000002995

College of Audiologists and Speech-Language Pathologists of Ontario. (2020). *CASLPO statement on anti-racism and the provision of ethical care*. https://caslpo.com/sites/default/uploads/files/INFO_EN_Group%20Email_CASLPO_Statement_on_Anti_Racism_and_the_Provision_Of_Ethical_Care.pdf

College of Audiologists and Speech-Language Pathologists of Ontario. (2022). *Guide for equitable & inclusive services.* https://caslpo.com/sites/default/uploads/files/GU_EN_Guide_for_Equitable_and_Inclusive_Services.pdf

Davis, K. (2020). Me and microaggressions: A framework for overcoming microaggressions incommunication sciences and disorders academic programs. *Journal of the National Black Association for Speech Language and Hearing, 15*(3), 78-83.

Day, L., & Beard, K. V. (2019). Meaningful inclusion of diverse voices: The case for culturally responsive teaching in nursing education. *Journal of Professional Nursing*, *35*(4), 277-281. https://doi.org/10.1016/j.profnurs.2019.01.002

Dogra, N., Conning, S., Gill, P. S., Spencer, J., & Turner, M. (2005). Teaching of cultural diversity in medical schools in the United Kingdom and Republic of Ireland: Cross sectional questionnaire survey. *British Medical Journal*, *330*(1), 403–404. https://doi.org/10.1136/bmj.38338.661493.AE

Dogra, N., Bhatti, F., Ertubey, C., Kelly, M., Rowlands, A., Singh, D., & Turner, M. (2016). Teaching diversity to medical undergraduates: Curricula development, delivery and assessment. AMEE GUIDE No. 103. *Medical Teacher*, *38*(4), 323-337. https://doi.org/10.3109/0142159X.2015.1105944

Dovidio, J. F., Kawakami, K., & Gaertner, S. L. (2002). Implicit and explicit prejudice and interracial interaction. *J Pers Soc Psychol*, *82*(1), 62. https://doi.org/10.1037/0022-3514.82.1.62

Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: Where does cultural education fit? *Australian and New Zealand Journal of Public Health*, 34, S87-S92. https://doi.org/10.1111/j.1753-6405.2010.00560.x

Ebert, K. D. (2013). Perceptions of racial privilege in prospective speech-language pathologists and audiologists. *Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse (CLD) Populations*, *20*(2), 60-71. https://doi.org/10.1044/cds20.2.60

Ellis, C., & Kendall, D. (2020). Time to act: Confronting systemic racism in communicationsciences and disorders academic training programs. *American Journal of Speech-Language Pathology*, 1-9. https://doi.org/10.1044/2021_AJSLP-20-00369

Elias, A., & Paradies, Y. (2021). The costs of institutional racism and its ethical implications for healthcare. *Journal of Bioethical Inquiry*, *18*(1), 45-58. https://doi.org/10.1007/s11673-020-10073-0

Equity and Inclusion Office, McMaster University. (2020, December 16). *Group intentions: Terms of engagement of fostering positive intergroup dialogue and relations*. [Presentation] Health Sciences Education Graduate Program, McMaster University.

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine*, *103*, 7–14. https://doi.org/10.1016/j.socscimed.2013.09.006

Finucane, T. (2014). Mention of a client's "race" in clinical presentations. *AMA Journal of Ethics Illuminating the Art of Medicine Virtual Mentor*, *16*(6), 423-427. https://doi.org/10.1001/virtualmentor.2014.16.6.ecas1-1406

Ginsberg, S. M. (2018). Stories of success: African American speech-language pathologists' academic resilience. *Teaching and Learning in Communication Sciences & Disorders*, *2*(3), 4. https://doi.org/10.30707/TLCSD2.3Ginsberg

Henry, F., & Tator, C. (2009). *Racism in the Canadian university: Demanding social justice, inclusion, and equity*. University of Toronto Press. http://www.jstor.org/stable/10.3138/9781442688926

hooks, b. (1994). *Teaching to transgress.* Routledge. https://doi.org/10.4324/9780203700280

Hordijk, R., Hendrickx, K., Lanting, K., MacFarlane, A., Muntinga, M., & Suurmond, J. (2019). Defining a framework for medical teachers' competencies to teach ethnic and cultural diversity: Results of a European Delphi study. *Medical Teacher, 41*(1), 68-74. https://doi.org/10.1080/0142159X.2018.1439160

Hubain, B. S., Allen, E. L., Harris, J. C., & Linder, C. (2016). Counter-stories as representations of the racialized experiences of students of color in higher education and student affairs graduate preparation programs. *International Journal of Qualitative Studies in Education, 29*(7), 946–963. https://doi.org/10.1080/09518398.2016.1174894

Jacobs School of Medicine, University of Buffalo (in collaboration with Dalke, K. & Chretien, K.C.). (2020). *Inclusive Practices in Case-Based Learning* [Internal working document]

Kendall, D. L. (2020). Systems of oppression in geriatric clinical service delivery. *Perspectives of the ASHA Special Interest Groups, 6*(1), 167-169. https://doi.org/10.1044/2020_PERSP-20-00215

Krishnan, A., Rabinowitz, M., Ziminsky, A., Scott, S. M., & Chretien, K. C. (2019). Addressing race, culture, and structural inequality in medical education: A guide for revising teaching cases. *Academic Medicine*, *94*(4), 550-555. https://doi.org/10.1097/ACM.0000000000002589

Lipson, J. G., & Desantis, L. A. (2007). Current approaches to integrating elements of cultural competence in nursing education. *Journal of Transcultural Nursing*, *18*(1_suppl), 10S-20S. https://doi.org/10.1177/1043659606295498

Loya, F., & Uomoto, J. M. (2016). Racial and ethnic microaggressions in the neurorehabilitation setting. In J. Uomoto (Ed.), *Multicultural neurorehabilitation: Clinical principles for rehabilitation professionals.* (pp. 261-269). Springer.

Mayes, M., Payne, M., & Franklin, A. D. (2020). One of one: Addressing feelings of isolation among black students in CSD. *Journal of the National Black Association for Speech Language and Hearing*, *15*(3), 15-1.

Merolla, D. M., & Jackson, O. (2019). Structural racism as the fundamental cause of the academic achievement gap. *Sociology Compass*, *13*(6), e12696. https://doi.org/10.1111/soc4.12696

Mohapatra, B., & Mohan, R. (2021). A proposed framework for increasing racial and ethnic diversity in communication sciences and disorders academic programs: The REAP model. *Perspectives of the ASHA Special Interest Groups, 6*(4), 755-767. https://doi.org/10.1044/2021_persp-20-00285

Ng, R. (1995). Teaching against the grain: contradictions and possibilities. In R. Ng, P. Staton, & J. Scane (Eds.), *Anti-racism, feminism, and critical approaches to education* (pp.129-152). OISEPress.

Ng, S. L., Wright, S. R., & Kuper, A. (2019). The divergence and convergence of critical reflection and critical reflexivity: Implications for health professions education. *Academic Medicine*, *94*(8), 1122-1128. https://doi.org/10.1097/ACM.0000000000002724

Nieblas-Bedolla, E., Christophers, B., Nkinsi, N. T., Schumann, P. D., & Stein, E. (2020). Changing how race is portrayed in medical education: Recommendations from medical students. *Academic Medicine*, *95*(12), 1802-1806. https://doi.org/10.1097/ACM.0000000000003496

Nixon, S. A. (2019). The coin model of privilege and critical allyship: Implications for health. *BMC Public Health*, *19*(1), 1-13. https://doi.org/10.1186/s12889-019-7884-9

Northwestern University Feinberg School of Medicine. (2023). *Inclusive & bias-free curriculum checklist*. MD Education. https://www.feinberg.northwestern.edu/md-education/learning-environment/checklist.html

Pilkington, A. (2013). The interacting dynamics of institutional racism in higher education. *Race Ethnicity and Education*, *16*(2), 225-245. https://doi.org/10.1080/13613324.2011.646255

Privette, C. (2023). Embracing theory as liberatory practice: Journeying toward a critical praxis of speech, language, and hearing. *Language Speech and Hearing Services Schools*, *54*(3), 688-706. https://doi.org/10.1044/2023_LSHSS-22-00134

Richburg, C. M. (2022). Underrepresentation of students from diverse backgrounds entering communication sciences and disorders programs: An investigation into the university student perspective. *American Journal of Speech-Language Pathology*, *31*(2), 613-630. https://doi.org/10.1044/2021_AJSLP-21-00010

Roberts, L. W. (2020). Belonging, respectful inclusion, and diversity in medical education. *Academic Medicine*, *95*(5), 661-664. https://doi.org/10.1097/ACM.0000000000003215

Romanello, M. L. (2007). Integration of cultural competence in physical therapist education. *Journal of Physical Therapy Education. 21*(1) 33–39.

Ross, H. (2014). Everyday bias: Further exploration into how the unconscious mind shapes our world at work. https://dent.umich.edu/sites/default/files/2019-04/Everyday%20Bias%20thought%20paper%20%281%29.pdf

Sanger, C. S. (2020). Inclusive pedagogy and universal design approaches for diverse learning environments. In C.S. Sanger & N.W. Gleason (Eds.), *Diversity and inclusion in global higher education: Lessons from across Asia.* (pp.31-71). Palgrave Macmillan. https://doi.org/10.1007/978-981-15-1628-3_2

Solotke, M., Sitkin, N. A., Schwartz, M. L., & Encandela, J. A. (2019). Twelve tips for incorporating and teaching sexual and gender minority health in medical school curricula. *Medical Teacher*, *41*(2), 141-146. https://doi.org/10.1080/0142159X.2017.1407867

Stone, J., & Moskowitz, G. B. (2011). Non-conscious bias in medical decision making: what can be done to reduce it? *Medical Education*, *45*(8), 768–776. https://doi.org/10.1111/j.1365-2923.2011.04026.x

Stowe, K. (2020). Breaking the silence: Action steps for eradicating racism in CSD. *Journal of the National Black Association for Speech Language and Hearing*, *15*(3), 19-21.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271. https://doi.org/10.1037/0003-066X.62.4.271

Sukhera, J., & Watling, C. (2018). A framework for integrating implicit bias recognition into health professions education. *Academic Medicine*, *93*(1), 35-40. https://doi.org/10.1097/ACM.0000000000001819

Suswaram, S., Perelmutter, B., Keuwo, R., & Gillispie, M. W. (2022). "I truly feel like I have been hustling on my own": Minority graduate students' experiences in communication sciences and disorders programs. *Perspectives of the ASHA Special Interest Groups*, *7*(4), 1106-1119. https://doi.org/10.1044/2022_persp-21-00273

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved* *9*(2), 117-125. https://doi.org/10.1353/hpu.2010.0233

Tsai, J., Ucik, L., Baldwin, N., Hasslinger, C., & George, P. (2016). Race matters? Examining and rethinking race portrayal in preclinical medical education. *Academic Medicine*, *91*(7),916-920. https://doi.org/10.1097/ACM.0000000000001232

Yu, B., Nair, V. K. K., Brea, M. R., Soto-Boykin, X., Privette, C., Sun, L., Khamis-Dakwar, R., Chiou, H. S., Fabiano-Smith, L., Epstein, L., Hyter, Y. D. (2022). Gaps in framing and naming: Commentary to "A Viewpoint on Accent Services". *American Journal of Speech-Language Pathology*, *31*(4), 1913-1918. https://doi.org/10.1044/2022_AJSLP-22-00060

Wagner, A. E. (2005). Unsettling the academy: Working through the challenges of anti-racist pedagogy. *Race Ethnicity and Education*, *8*(3), 261-275.

Whitehill, T. L., Bridges, S., & Chan, K. (2014). Problem-based learning (PBL) and speech-language pathology: A tutorial. *Clinical Linguistics and Phonetics*, *28*(1-2), 5-23. https://doi.org/10.3109/02699206.2013.821524