Microaggressions: Underrepresented Minority Physical Therapist Student Experiences While on Clinical Internships

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ABSTRACT

Purpose: The purpose of this study was to determine whether underrepresented minority (URM) students in the University of Wisconsin-Madison (UW-Madison) Doctor of Physical Therapy (DPT) Program had experienced derogatory behavior while on clinical internships.

Methods: Six URM students were surveyed while on clinical internships to ascertain whether they had encountered discrimination, racism, or microaggressions.

Results: Four of the 6 URM students reported experiencing microaggressions while on their clinical internships.

Conclusion: Education and training in the recognition and management of incidents involving derogatory behavior are imperative to foster safe and inclusive clinical environments.

INTRODUCTION

Health care professions, particularly physical therapy, have been historically homogenous. The diversity breakdown of the physical therapy workforce is starkly different from that of its patients. Whereas US Census data indicates that Whites of non-Hispanic origin make up 60.1% of the United States population, they comprise 88.5% of the American Physical Therapy Association (APTA) membership and nearly 80% of the reported physical therapy industry (Table 1).[1-3]

This 1-dimensional White workforce is a deterrent to providing the highest quality care to each patient who seeks physical therapy. A diverse workforce is essential to meet the cultural and societal needs of an increasingly diverse patient population. All patients desire access to clinics that reflect their neighborhoods and want to feel understood by their providers through the delivery of culturally competent care. "Helping a patient become healthier," says Morehouse School of Medicine Dean Dr. Valerie Montgomery Rice, "partly depends on a patient's trust in a doctor, a positive doctor-patient relationship, and an understanding of the patient's environment. And many times, that occurs through a cultural lens. If you can relate to something about that person's story—or have some indication of what their experience has been—then the recommendations you make as a provider (are) going to make a difference."[4]

The most practical way to increase diversity in the workforce is through the admission of URMs into educational programs. Table 2 illustrates the low percentage of diverse applicants to physical therapy programs and, more disappointing, the disproportionate percent of URMs who apply but are not admitted to programs.[5] The UW-Madison DPT Program has struggled with recruitment of diverse applicants; however, due to increased outreach efforts and a more holistic admissions review process, the program is starting to see an increase in URM numbers. As a result, the DPT Program has been focusing on providing a safe, equitable, and inclusive learning environment where all students, faculty, and staff can thrive.

Program strategies to foster inclusivity have included mandatory faculty participation in cultural awareness and responsiveness education and training that is tied to annual reviews; student, faculty, and staff completion of implicit bias tests and required participation in the Intercultural Diversity Inventory, a continuous intercultural competence development tool that can be used to gauge both progress as an individual and as a program; and access to ongoing resources to guide inclusive teaching and cross-cultural communication. Efforts are underway to create a framework for

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Table 1. Diversity in the United States and in the Physical Therapy Profession

Source	White (not of Hispanic Origin)	Hispanic or Latino	Black or African American	Asian	American Indian or Native Alaskan	Native Hawaiian or Other Pacific Islander
US Census (2019)[1]	60.1%	18.5%	13.4%	5.9%	1.3%	0.2%
APTA Membership Data (2016)[2]	88.5%	2.5%	1.5%	5.4%	0.4%	0.2%
WebPT Industry Data (2018)[3]	79.4%	4.0%	2.2%	5.7%	0.7%	0.4%

Abbreviation: American Physical Therapy Association

Table 2. Percent of Total Applications to Physical Therapist Centralized Application Service Member Programs 2011-2012 by Race/Ethnicity Designations

	Total Applicants 2011-2012	Accepted Applicants 2011-2012
White (not of Hispanic Origin)	66.44	71.58
Hispanic or Latino	5.28	4.31
Black or African American	5.21	3.2
Asian	8.27	6.9
American Indian or Native Alaskan	0.97	0.68
Native Hawaiian or Other Pacific Islander	1.12	0.68
Declined to state	12.7	`12.65

culturally responsive pedagogy and instructional practices. Faculty are focusing on threading diversity, equity, and inclusion throughout the curriculum via content as well as educational materials. Students explore their own cultural awareness and delve into the history of health and health care inequities and the resulting disparities, the social determinants of health, and the existence of rehabilitation deserts. Students then have an opportunity to practice what they learn by partnering with community organizations on a project and through participation in a plethora of activities such as pro bono clinics.

Community engagement and outreach also are conducted through the program's DPT Student Organization (DPTSO) and Advancing Diversity and Excellence in Physical Therapy (ADEPT) group, respectively. If there is one thing that faculty and staff have learned on this journey, it is the importance of listening to and learning from students. As a result, many faculty and staff have joined students in DPTSO and ADEPT activities.

The DPT Program has tried to ensure that its physical space reflects its student body and that all major holidays and celebrations are acknowledged. In addition, the program furnishes a public statement affirming its commitment to diversity. Finally, there must be a vehicle through which students can report traumatic events; in the program's case, this resource has been devised by the UW School of Medicine and Public Health. Again, the significance of listening to and supporting URM students cannot be overstated.

But what happens when inclusivity is not carried over into the clinical environment? Students are taught to value patient-centered care, demonstrate professionalism, and to use effective communication skills, but what is the protocol when they experience discrimination, racism, or microaggressions from patients or staff during their clinical internships? Medical staff and students customarily have believed that they must tolerate patient biases in the interest of quality care provision. These patient behaviors can range from refusal of treatment to derogatory and demeaning comments, usually based on the provider's race, ethnicity, religion, sex, or gender identity.[6-8]

The impact of these encounters can lead to decreased confidence, discomfort, and tension, especially when the clinical care team does not know how to address the discriminatory behaviors. Ackerman-Barger and Jacobs assert that "microaggressions have been shown to have a dose-response relationship with depression and anxiety."[9] The authors go on to explain that chronic stress due to daily experiences of discrimination and microaggressions can be associated with cardiovascular disease, obesity, and diabetes. On top of mental and physical health, they can take a toll on intellectual function. This cognitive load has a counter-productive effect in retaining diverse students. Microaggressions also can take an emotional toll on providers that can result in exhaustion, self-doubt, and cynicism, in addition to withdrawal from their clinical roles. Bystanders can experience moral distress and apprehension about what to do in these situations. Reasons for not speaking up can include lack of skills, uncertainty about support from others and the institution, and doubt about the outcome if they were to come forward.[10]

In the past, these incidents have tended to be ignored and concealed due to discomfort of confronting the patient or staff member. Ackerman-Barger and Jacobs give an example of a URM nursing student who says that she reminds herself to keep her head down and mouth shut to avoid drawing attention to herself.[9] A URM physician reflects, "Sometimes a patient or family behaves or reacts in an unexpected or outrageous way, which is surprising, shocking, or even confusing. I often find myself stunned, feet weighted, mouth paralyzed. My mind whirls to make sense of the unexpected departure from the customary script. If I am in a room with other professionals, I look for their reactions to guide me. When no one reacts, I wonder, 'Is it all in my head? Did I really hear that racial slur or that sexist comment? Did I exaggerate it? Am I being too sensitive?'"[10]

Fortunately, in the last year, civil unrest has brought these injustices to the forefront. Providers are speaking up and institutions are creating policies and trainings that continue to support patient autonomy, while protecting and respecting staff and students.[11-14] UW Health Policy Number: 1.2.22 Patient, Family, and Visitor Discriminatory Requests of Behavior is one such policy, with a stated purpose of ensuring safe, timely, culturally competent, and

quality patient care while protecting staff from bias, discrimination, and disrespect.[14]

Volume 95, December 2020, of *The Journal of the Association of American Medical Colleges* is dedicated to "Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments." Its 27 papers call for urgent action to eliminate health care disparities and advance health equity along with a more diverse workforce by mitigating harmful bias and discrimination in our health professions learning environments and clinical care sites.[15] Themes include culture change, listening to learners, and creating bias-free assessment and evaluation, from admissions to clinical training programs. As Warsame and Hayes conclude, there is a difference between patient preference and patient needs.[13]

The purpose of this pilot study was to determine whether any of the UW-Madison DPT Program's 6 first-year URM students had experienced derogatory or discriminatory behavior while on their 4-week internship.

METHODS

This study was part of a larger investigation that focused on how URMs in the UW-Madison DPT Program learned about the physical therapy profession; the barriers and facilitators they experienced from the time of interest to their matriculation through the program; and any suggestions they had to increase recruitment of URMs. Since this survey went out at the time of the George Floyd incident, and we had first-year students on an internship at that time, we decided to add a question about whether these students had experienced discrimination, racism, or microaggressions during their clinical rotations and, if so, how these situations were handled. This study was reviewed by the UW-Madison Institutional Review Board and was granted an exception.

An email was sent to all 120 students (3 classes of 40) in the DPT Program asking for participants who self-identified upon admission as underrepresented. URM students who responded were then sent the Qualtrics survey. The definition of underrepresented was adopted from the Physical Therapy Centralized Admissions Service (PTCAS), with categories of Hispanic/Latino, American Indian or Alaskan Native, Black or African American, Native Hawaiian or Pacific Islander, or White. The participants were considered indirectly identifiable and a waiver of signed consent was included so they could opt out of being directly quoted without use of their name if desired. Data was deidentified and stored in a secure online Box file (Box, Inc., Redwood City, California) to maintain confidentiality.

Out of 120 students surveyed, all 19 URM students from the 3 classes responded to the survey. Of those 19 students, all 6 students from the first-year class responded to the question related to current clinical experiences regarding discrimination, racism, and microaggressions. The following operational definitions for each of these terms were provided:

- *Discrimination*: the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex.[16]
- *Racism*: Prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership of a particular racial or ethnic group, typically one that is minority or marginalized.[16]
- *Microaggressions*: indirect, subtle, or unintentional discrimination against members of a marginalized group.[16]

RESULTS

Four of the 6 URM students surveyed stated they had experienced microaggressions on their current internships. One participant abstained from describing details; however, the other 3 students reported the following:

> "Multiple times now, patients have made inappropriate comments about my ethnicity. I am no stranger to this and feel I have handled it well, either ignoring it or changing the subject. I was once asked if I am 'going back to Mexico.' I was taken aback by the remark, being a Midwest native who has never been to Mexico. Sadly, I continue to anticipate that I will receive these types of comments. I look forward to the day patients treat their providers with the same respect that we do to them."

> "I had a patient who repeatedly asked what race I was and refused to work with me. I also had a patient who stated that he was proud of me for pursuing a real career because most Black people don't have real jobs."

> "I was treating an older White woman with an ankle sprain. She grabbed and rubbed my hair and said 'Wow, your hair is just so fun.' I was immediately taken aback. My clinical instructor (CI) and I talked about how what she did was inappropriate. I saw the same patient 2 more times, and she touched my hair both times and made a remark about how it felt. I felt very uncomfortable with this. My CI had stated that they would intervene if it happened again, but they did not. Looking back, I should have said something right away to stop this behavior; however, I did not know how my CI would respond to me doing so."

All 3 of the aforementioned examples involved patients and students; however, these interactions can also involve clinical instructors, staff, coworkers, faculty, and/or peers.[17] In addition, when the director of clinical education was reviewing student internship evaluations, she noted the following comment by a clinical instructor: "We have a patient that has expressed racist views/comments, and [the student] was able to stay neutral, not inciting these expressive views, nor upsetting the patient."

DISCUSSION

Until this past year, the UW-Madison DPT Program was blameworthy of not investigating the individual experiences of our URM

students. We were mortified to learn that 4 out of 6 students had encountered microaggressions on their current internships. As we began to explore why these incidents had not been brought up in the past, we learned about "racial battle fatigue," which is explained as follows. "People of Color experience daily battles of attempting to deflect racism, stereotypes, and discrimination in predominantly White spaces and must always be on guard or weary of the next attack they may face. Both the anticipation and experiences of racial trauma contribute to Racial Battle Fatigue."[18] Through discussions with our URMs, we also learned that persons of color experience a "minority tax;" they tire of being the sole representative of their race and grow weary of educating others on what they go through on a daily basis. As students, power differentials, along with lack of experience in situations such as clinical internships, deter them from speaking up under normal circumstances, let alone when they are the being denigrated by a patient or staff member.

Moving forward, we can assume that these situations ***do*** occur and that we need to learn how to step in when the person who is harmed does not feel comfortable doing so. But we must also take a proactive and not just a reactive approach to managing microaggressions. It is crucial to learn and practice what to do if one commits, receives, or witnesses these situations. Fortunately, policies, education, and trainings have now been devised that offer actionable steps to protect URMs.[11-14] Included in the UW Health policy and training are a Decision Tool Matrix to help guide the reader through appropriate responses given the circumstances and a Guidelines and Key Responses tool when the reader has committed, witnessed, or received a microaggression. Unfortunately, these guidelines were not in place at the time of our students' internships in May 2020. We hope this is the beginning of a culture shift that protects and supports the victims of microaggressions in the moment they occur, while simultaneously attempting to educate the aggressor.

The primary strength of this study was initiating a much overdue conversation on the hardships our students of color endure on a daily basis. The primary weakness of this study was the small number of participants. However, our findings have kindled a larger-scale investigation involving focus groups with physical therapists, physical therapist assistants, and students. We are evaluating participant recognition of discrimination, racism, and microaggressions; their experiences as the target of or witness to these behaviors; the management of these encounters when they occurred; and education and training that they would find useful to address these situations moving forward.

CONCLUSION

The results of this pilot study can and should be applied to all other health professions programs. As medical practitioners, it is time for us to develop strategies that ensure safe, inclusive clinical environments. As situations involving derogatory behaviors occur, it will be critical to not only zoom in to the individual incident but to also zoom out to the system and its policies that are enabling these behaviors to occur. Finally, I would like to conclude with a quote from an article entitled, "Why are there still so few Black CEOs in America?"

> "[Dick] Parsons [senior adviser at asset management firm Providence Equity] says he's old enough to 'have been at this place before' in the late 1960s and early 1970s. 'You could have literally taken the headlines from those days and moved them forward 50 years to George Floyd and that reaction,' he said. What he does not want to see are the same headlines a half-century from now. 'What we have a tendency to do in business, in particular, is throw money at a problem. Money is important but it's not going to solve this problem all alone. We have to look at how the structure of our economy works and make changes. That's the next step. And that's going to be hard,' he said. 'As a practical matter, it means taking from those who have privilege, privilege that they are sometimes not even aware of, and giving to those who have not had that privilege, who truly are on an unequal footing. That's much tougher than just giving money.'"[19]

We need to be intentional in changing a culture that has existed as the status quo since the inception of our country. Racism is deeply embedded in every aspect of our society. Dismantling pervasive racism will take changing institutional, systemic, and cultural policies and practices that manifest and support racism. This will require speaking out–we must keep the conversations going as a lifelong practice. George Floyd was just another day in the life of a person of color and we have been down this road before, but maybe this time, we can keep charging forward and not become complacent once the initial unrest dies down. We owe it to those who have been unfairly disenfranchised! It is essential that we work together and push each other–it is the only way we can create a truly inclusive society characterized by mutual respect and equity.

Funding/Support: None declared.

Financial Disclosures: None declared.

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