Recommendations for Managing Patient Conflict Resolution for Audiologists and Graduate Clinicians

Presenter: Shade Kirjava, AuD, ABA-C; Ricardo Vallejo, BS

- [Christy] Welcome to the classroom, everyone. I'd like to present today's guest speakers, Dr. Shade Kirjava and Ricardo Vallejo. If you'd like to read more about either presenters, you can read their bio on the course registration page. But at this time, I'd like to hand the mic over to you, Dr. Shade Kirjava.

- Howdy. Thank you. Yeah, I'm so glad to be here. My name is Shade Avery Kirjava. Feel free to call me Shade. I use they/them pronouns. Ricardo, do you wanna just briefly introduce yourself?

- Sure, my name is Ricardo Vallejo. I use he/him pronouns, and it's a pleasure to be with you all today.

- Absolutely. I'm so glad you could join us for this. I'm so excited to talk about this topic, but I did just wanna cover a few things first. We have some disclosures. I'll let you read over those. And I also wanted to just briefly mention our learning outcomes for today. After this session, we're hoping that you'll be able to list and understand the populations at particularly high risk of prejudice and discrimination. You'll be able to identify the kind of things, the words and actions that can be prejudiced or discriminatory when said by patients, and you'll discuss how to deescalate or redirect these patients. I think this is such an important topic, talking about the experiences of our clinicians and how they interact with patients is absolutely essential.

Before we really dive into any of the content though, I think it's important to think about our positionality. You might remember that positionality is the identities that we have. It's the experiences that we have and how that relates to how we think about things, the reasons that we do the things that we do, the reasons that Ricardo and I chose to do this presentation, why we think it's an important topic. So, I've shared just a little bit of background so you can understand why we're talking about this particular content. I'm actually a vestibular audiologist. I work in a private practice in Los Angeles, and I'm

actually finishing up a PhD in public health right now. The focus of my work personally is it's things like health disparities.

It's things like the unfair, avoidable differences in hearing health that some populations have. It's on topics like diversity, equity, and inclusion, and thinking about the experiences of historically marginalized groups, including clinicians and AuD students. Some of the particularly relevant identities that I have, I've listed here. And please remember that if you have any questions about any of this, about what non-binary is or what asexual is, about the specific content of this presentation or any other questions, please feel free to drop them in the Q&A at any time. We'll take plenty of time at the end to make sure that we have time to troubleshoot and talk through these things. Ricardo discussed his positionality as well, and I'd actually like for you to do that too.

I think, before we get started, let's kind of think about what are we as clinicians and as people bringing to this discussion, what important identities do we have that can change how we understand and interpret these issues. So I'm actually gonna set a timer. I'm gonna give you just one minute, about 60 seconds. Think about the important social identities that matter to you. It could be things like your race or ethnicity. It could be things like your nationality or the region that you live in. It could be other things. Think about what are the social identities that really matter to you. I'm gonna give you just a minute. And don't worry about responding in chat or listing this.

This is just something more for you to think about and be aware of. Okay, I'm gonna give you just a few more seconds. Think about what identities you have that can be relevant with patients that interact or that affect the way that we interact with others. Okay. Think about some of the identities that are important to you that you recognized. Do they affect how you interact with others? If you thought about things like race or ethnicity, I think that that can affect the way that we interact with patients. It affects the

dynamics and the communication that we have. So it's relevant to think about what is our positionality as clinicians, what is our experience, and how do others perceive that.

That is going to be helpful as we continue this discussion. Something else that I think is valuable for us to do before we really dive into the meat of what we're thinking about is kinda recognizing that patients can kinda be really cruel, or prejudiced, or discriminatory, but we want, as professionals, to maintain a healthy, productive relationship with them whenever we can. So even when we're angry, when we're frustrated, when patients do things that really just don't seem reasonable, I think that it's good to kinda reframe away from blaming patients or trying to identify where blame should be. And we can think about, how do we manage this situation? How do we help a patient regardless of this?

How do we help keep our students and our other staff safe and productive? So when we're thinking about the questions that we might ask or troubleshooting specific situations, let's use statements like I statements. We can say like, I feel that this situation or I notice that this patient said. It just kind of avoids placing blame or avoids a more accusatory tone, and it helps us maintain that rapport with patients and helps keep the focus on troubleshooting and on maintaining that productive, healthy relationship with our patients, with our students, and with our staff. I think that there's a lot of reasons that you should care about this, and I don't even think it matters if you are a clinician, if you work in a private practice or a hospital, if you're an AuD student.

I think that everyone who has that direct patient contact needs to be aware of these issues for a lot of reasons. I did briefly just mention that my background is actually in public health. So a lot of my work is looking at bigger, not patient-specific factors, but looking at social factors across the country, or looking at geographic factors, or looking at trends across time, looking at not this individual level information, but much bigger discipline and field level information. And there isn't a ton of research on this in

audiology on the really broad or generalizable experiences of prejudice, or harassment, or discrimination in audiology specifically, but what we do know is that it's pretty common. We've seen some research, especially in the last few years, that many students, audiology students and full clinicians, experience harassment, prejudice, other types of bigotry.

And I'm noticing a question talking about what does it mean to be asexual, non-binary, and cisgendered? Those are wonderful questions. I'd love to have that conversation, and we'll actually cover that at the end in the Q&A. Yeah, these are definitely terms that are good to be familiar with. If you have other questions, put them in the Q&A. I'd love to have that conversation at the end. We can see, especially in the research and other fields, like nursing medicine, dentistry, we can see that people with historically marginalized identities that try to work in these fields, they often experience harassment more often than people with other more socially accepted identities. When we talked about positionality, I mentioned that I identify as white, and that it changes my experiences.

Being someone who is non-binary, it means I'm transgender, and that means that I can experience sometimes harassment or discrimination because of that, but less likely because of my race. We see that, depending on these historically marginalized identities that we have, you might be at higher risk for these experiences. So we need to be aware of these identities that we have in ourselves and then others around us have. These negative experiences are so common that in ASHA's public policy agenda items for the 2023 year, harassment was something that they even focused on. They stated that it's important to have appropriate and safe working environments, and we're seeing that this kind of negative interaction in healthcare settings has been getting increasingly common, especially since the onset of COVID-19 pandemic.

We're actually seeing, even before that, healthcare workers about five times more likely to be injured by interpersonal violence at work than workers in other fields. Being a healthcare worker is a bit more dangerous than other jobs. I think, in audiology, that's somewhat less of a concern than a more inpatient settings like maybe nursing or medicine. We don't necessarily have the same types of interactions or work with patients in the same kind of settings that are particularly prone to those interactions. But we also have been seeing that, since the onset of the COVID-19 pandemic especially, medical mistrust has been increasing, and we're also looped into that as healthcare providers. There's been this trend of not necessarily trusting professionals, doctors, healthcare providers, and having this kind of animosity towards them.

We've been seeing that that does increase the harassment that people experience. We'll talk more about that in just a minute. And we also see that we, as supervisors, really need to be aware of these dynamics and these issues because students don't always report or discuss it. They don't always volunteer to have those discussions because it might affect their careers. When I was a fourth year clinician, I actually worked at a VA hospital. I was considered an employee, and I experienced, and I was glad to have all of the anti-discrimination protections and employment protections as a VA employee, but not all fourth year externs have that. Some are not considered employees, and many people feel that because they're practicing under someone else's license, really they're students and they shouldn't necessarily have the same protections from discrimination that others have.

We're also noticing that when we have these hostile clinical encounters, like harassment, bigotry, discrimination, and we'll talk more about what exactly all that means and differentiate them in a bit, we're seeing that when we experience those things, it affects our performance at work. This is actually a graph from one of my recent projects looking at medical errors. And in a related topic, when we experience these harassment, prejudice, or discriminatory experiences, we can see the box at the

top, we can see that that leads to higher stress. We can measure that a lot of ways as psychological stress, as allostatic load. We can measure biomarkers, and look at what are the hormone levels in people's bodies and how they're affected by stress.

And however we measure stress, we see that when we're more stressed from these experiences, from people being discriminatory or prejudice towards us, it causes us to be poorer at school. Less of a concern for US clinicians, but for our clinicians that are graduate clinicians, they are also students. They're also learning. They're growing. And if they're experiencing this prejudice, they're more distracted and less focused on their education. There has been research that their education is worse. They learn less. We don't wanna have an environment where we invite students and then we have an environment where students can't effectively learn the skills they should. We also see that even clinically seeing patients, if we're particularly stressed or flustered, if we're not sure if we have support of our supervisors, then our experience is worse and our practice is worse.

We also see that burnout gets worse if we're in a more high stress job, and all of these things make it more likely for clinicians to leave audiology. We're talking a little bit about why particularly driving historically marginalized clinicians out of audiology really isn't ideal. And we also see that when we're in these stressful environments, it affects our mental health. It affects our physical health. It makes mental and several physical illnesses more likely. These kind of stressful interactions with patients, some people say that when we got into healthcare, this is something that we invited, but I think this is something we need to be aware of and we need to know how to manage so that we can effectively manage these.

And I think, because of all this, we should also especially be thinking about how these experiences affect the care that we provide for patients. Ultimately, that I think is what matters most. And we find that when we're more stressed because of discriminatory or

prejudice experiences, we have more medical errors. In audiology, it's not necessarily something where someone would have a life-threatening complication, but we can have problems in earmold impressions. We can have problems cerumen management. We can cause harm to our patients. We could misinterpret our tests and we could cause infections from poor infection control. We might not document correctly. These kind of errors, research has shown, get more common when we're more stressed, when we have less time at work, when we feel more pressure.

So these are all experiences that we should be thinking about. This prejudice and discrimination can cause direct patient care results. It can affect our direct patient care. So far, I've kind of been grouping these things together, prejudice, or discrimination, or bigotry, or harassment, and we're gonna keep doing that for the rest of this talk. We're not going to clearly differentiate them because, for the purposes of this, of managing these negative hostile interactions between patients and clinicians, it's not necessarily as important, I think, to exactly define, is it prejudice or is it harassment? What exactly is it? I think it's more helpful to focus on, how do we respond to these situations? How do we manage these situations?

So if you look in the research and if you start to do some reading, you'll notice that these are all different and they're all defined differently and measured differently, but at least for the purposes of this, we're kind of grouping them all together in negative patient interactions. I'm seeing another question in the Q&A. Thank you. We'll definitely talk about that at the end. If you have other questions, feel free to drop them in at any time. Before we really dive into more of this content, I think it's helpful to understand since the historically marginalized identities that we have affect our interactions with others, what kind of identities are present in audiology? How does that color help people interact with our profession?

And like I'm sure you've noticed, audiology, people have identified it as a pretty segregated profession. Only about 13% of AuDs that are members of ASHA are male, and that number's getting even smaller, even fewer first year students are male. People have identified audiology as a sex-segregated profession, and that has implications for how people interact with us as clinicians. It can make, for example, sexism more common because women, female healthcare providers especially tend to experience experiences of sexism more often than their male counterparts. We also notice that people who identify as white are about 62% of the overall American population. About 94% of audiologists working in America are white, and that influences things like the racial and ethnic identities and interactions that we have.

So we need to be aware that these are the identities that we personally have, and these are how people understand our field, and that color is how they interact with us and with the discipline of audiology generally. Some of this content is actually from this. First section especially is from medicine because there just hasn't been too terribly much research on this in audiology specifically, but, at least for medical students, harassment is pretty common. We see that medical students experience verbal harassment, sexual harassment, physical harassment, and violence. And we know that this can affect anybody. Regardless of your identity and your positionality, you can have these negative experiences of harassment and bigotry. And we know that these experiences are particularly more common when we have those historically marginalized or socially stigmatized identities.

For example, a minority religious identity, a gender diverse identity, and we'll talk more specifically about that in just a minute. There's also been some thought that, in audiology, our average patient is older than in other fields. In other allied health disciplines, the average patient might be a bit younger. But since our patient load is often a bit older and we see that older folks, research has identified that they might be more likely to have these prejudiced or discriminatory views. That might even be more

common in audiology than in other allied health disciplines. This is really important for us as audiologists to be aware of. And there's a few different populations that are at higher risk of these experiences.

We've mentioned a couple just briefly. We know that when we have women who are working in healthcare as healthcare providers, they tend to experience harassment a lot more than their male counterparts. Particularly sexual harassment is a lot more common. And of course this is really relevant for audiology with the vast majority of audiologists identifying as women. But other populations like people with minority religious identities are also at higher risk of harassment. So there's been a lot of research into how these experiences changed, first, after 9/11 and, more recently, with the recent conflicts in the Middle East. It changes how people view and interact with others that they perceive as having a different religious identity than them. These kind of experiences are changing how people interact with us, and we also see this happen for anyone who others aren't really perceiving as white.

And we can go and look at the writings of WEB Du Bois, and we can look at the historical basis of these, but really it's something that's an everyday experience for a lot of folks. Particularly since COVID-19 pandemic, there's been a lot of harassment and increased harassment against people that others perceive as Asian. Looking at physicians specifically, we're noticing that, for Black physicians, they're much, much more likely to experience harassment than their white counterparts, with similar trends for Asian, Latine physicians. And there's less research available for other people with other ethno-racial identities, but the research does seem clear that when we have these not white historically marginalized identities, we're more likely to experience harassment. We also see that people who have an LGBTQ+ identity, just briefly, that stands for lesbian, gay, bisexual, transgender, queer, and other identities, are more likely to experience harassment, especially people who identify as either transgender or bisexual.

I mentioned just briefly that I'm non-binary. It's a flavor of being transgender, and we can talk about the specifics later if you like, but that's absolutely an identity that's stigmatized and that many people view as morally wrong, so that does invite harassment, And that also often gets hidden out of fear of harassment. Similarly, people who have visible disabilities often hide their identities or their disabilities. We don't, as clinicians, want to cause these negative interactions with patients. We don't wanna cause these problems. We wanna help our patients as best as we can. So sometimes there's this pressure to hide these identities that could cause conflict with our patients, but that also isn't necessarily reasonable or fair.

Personally, I use they/them pronouns. I'm not a man or a woman, so it's really not acceptable to call me he or she, and sometimes it can be helpful to mention that. It's okay to tell patients, "I use they them pronouns. This is how you can refer to me correctly." Just like how we mentioned if we'd prefer to go by doctor last name or just use our first name. It's okay to be referred to that way, and sometimes that requires having that conversation with patients. It's not necessarily acceptable to hide the identities and the people that we are if it's relevant to how we just talk with patients. Another focus of some of my work specifically is how people who have an immigrant identity or who people view as foreign, or different, or other, they're often at higher risk of these negative experiences and harassment as well.

I'm sure you have noticed this, at least in pop culture, if you haven't noticed it in your personal life. But in addition to all of this, we also see that we have this phenomenon that we call intersectionality. People with any of these identities, with a disability, with an LGBTQ+ identity, or the others that we've talked about, they do individually increase these experiences of harassment or discrimination. But when we have several of these identities, they also interact. They cause unique intersectionality or unique experiences at the intersection of several identities. I just briefly mentioned that being both white

and transgender, it changes my experiences. Each of those identities affects how others interact with me and how patients interact with me in clinic, but those identities together cause me to have different experiences in someone who, for example, is transgender and black.

We see that people who have several of these identities tend to have even more harassment and more negative experiences in people that have just one. Take a moment. Think back to the identities that you identified for yourself. We talked about your positionality and you identified some of the social identities that you have that can affect how you interact with others. Think about, are any of them listed here? Do you think could they interact? Could they affect... I'm sorry. Could they intersect and affect the way that people interact with you in more complex? As we go forward, we'll talk a little bit more about how you can respond to this and what you can do about it.

And then at the end, I see we're having a few more questions come in. Thank you. If you have other questions at any point, definitely put them in, and we'll have time at the end to go through our questions and to troubleshoot some of these as well. But for now, I'm actually gonna turn it over to Ricardo, and we're going to talk more about how we can recognize and respond to these situations.

- Alright, so as clinicians, it's really important that we're able to recognize prejudice in our clinical interactions. Think of ways that we can implement responses and also have the follow-up discussions necessary to kinda tie up all these loose ends. And ultimately, this becomes even more important when we're working with students that we're supervising. So here we have a case history. I'm gonna give you about 30 seconds to read through it. But while you read through it, I want you to think of what in this case to be identified as being discriminatory, or biased, or prejudiced language, or behavior. Think about the intervention that was implemented here, and also think of the aftermath and the effects that this can have on the parties involved.

So I'll give you guys about 15 to 30 seconds to read through this, and then we'll move on to the next slide where we'll discuss it a little bit more in depth. I'll give you guys just a couple more seconds. All right. So again, thinking about what in this case could be identified as being discriminatory or prejudiced language or behavior, what the intervention was in this case, and the aftermath. And also think about what could have been improved in this situation or what didn't go well. We'll talk a little bit more about that in the next slide. So what was a discriminatory behavior or language here? And it lies in this question of, where are you from? Now, this might seem like a simple question, but it really just depends on the demographic of the recipient.

So in this case, Diwa is a student of color, and the first thing she experiences when she's talking with this patient is this question of, "Where are you from? Your name's Diwa. That's a very interesting name." And ultimately, this language is used uttering exclusionary language. And ultimately, it's to make Diwa feel as if she does not belong in a space that she's occupying. It's a way of reinforcing the notion that she's different than everyone else based on her appearance and her name. And ultimately, it kind of makes it seem as if all her other identities don't matter because her appearance and her name is what makes her so much different than everyone else. The intervention in this case is that Diwa's supervisor chose to intervene by introducing herself to keep the appointment moving along.

But the aftermath of the situation is that it was a busy clinic and Diwa's supervisor run to another commitment. It's very realistic to what everyday clinic life can be like. Sometimes you don't always have the time to kind of take a second to reassess or talk about what happened in clinic that day. And ultimately, this does a disservice to Diwa because we don't know how she's feeling after this situation. So I want you guys to take a couple of seconds to think about what not addressing this situation with Diwa might make her feel, and we'll talk a little bit more about that in the next slide. So take

a few seconds to think about how the situation may have affected Diwa, especially as a beginning clinician.

So when we think about what she might be feeling, some feelings may arise such as isolation. So maybe this just highlights that something Diwa already knew. Maybe she's working in a clinic where she's the only student of color in that clinical rotation that day, and it's just a reminder that, hey, she's different than everyone else. It may also lead to a sense of inadequacy. So maybe she's thinking, "Hey, I'm already being questioned just by introducing myself to the patient about why I'm in this space. Who knows what they're gonna ask me when I'm actually providing them hands-on care?" So it can also make her feel like she's not good enough to be in that space.

On the perception of being a liability or a burden, this is especially applicable when she's thinking about how she's communicating with her supervisor. So maybe she's thinking, "I don't wanna create more work for my supervisor. She's already busy rushing to a meeting. The last thing I want is to bring this up to her and her to be stressed by this, or think it's more work to work with me and supervise me." And the last one is a sense of detachment or disassociation from the event itself. So for a lot of students, me included, when I was being supervised by various clinicians, even if they brought up a situation that's similar to this one with me, sometimes I just think it's more work to address it, to talk about it.

Maybe Diwa's thinking that this is just how things are, I should get used to it, nothing's really gonna change if I'm in this clinic versus another one. I'll just disassociate from it and think that it'll all be okay. But ultimately, I think this does a great disservice to everyone involved because, no matter how big or small these events of discrimination, bias, prejudice, or discrimination are, they have potential to have long-term consequences that are usually negative. And it's important to think about this in a way such as it can snowball. So this one negative incident might go home with you. It might

cause a little bit of stress in your personal life that day, might not study as well for that exam.

And ultimately, when you take the exam, you don't do so well. And then it becomes an issue of whether or not you might pass the class, and then it can lead to other things that ultimately end up having negative consequences on a student especially. It's also really important to think about how this might affect you just as a clinician practicing alone. We all take a a certain amount of stress home from work with us. It's unavoidable, but, ultimately, it's really important to think about this in the grand scheme of things, especially when supervising students. I also think it's really important to think about why clinicians might choose an indirect approach of addressing patient bigotry. For one, it's a bit more comfortable to just gloss over it or pretend it didn't happen.

No one wants to damage rapport with the patient. We all want our patient to like us. We all want our patient to trust us in providing them care. Bringing up this touchy subject and calling them out on their behavior might damage that. It might make them uncomfortable and ultimately make you uncomfortable and kind of affect the amount of patient care or the quality of patient care being given. But there are consequences of not addressing this behavior, and what are those? First, especially if you're supervising a student, it might make the student feel as if you don't really care about their wellbeing or their clinical education if you're just taking the backseat while this student's being interrogated in a situation such as Diwa's.

Diwa might think that, "Oh, this is... You agreeing with what the patient's saying?" So it's really important to think about how the student might perceive you not intervening in a situation similar to this. And I think one of the most detrimental consequences is the normalization of this behavior. So if this patient feels comfortable saying these things or demonstrating this behavior with this provider and student, what's stopping

them from doing it with another provider they might see who's different than the one they have today. So ultimately, it perpetuates the cycle if you don't intervene. So that's why it's really important that if you encounter patient bigotry, and especially in a more severe, or if it escalates, it's really important that you address it real time.

Okay. So at the heart of all this are three points that are, I think, particularly useful in terms of preparing for prejudice. So the first is allyship that requires mutual respectful relationships between the provider and the student. Additionally, the point that patient bigotry must never be ignored and it should be addressed as soon as possible. We wanna foster a safe learning environment for the students that we work with or just a safe healthcare environment for the patient that we're seeing. And also, this normalization of calling out this behavior 'cause, ultimately, by normalizing calling out this behavior, we're going to have more safe optimal learning environments for everyone involved. So how do we do this? At the heart of all this is if there's effective communication between the preceptor and the graduate clinician, there has to be honest open communication for any of this to work.

I want you to take a second to think about, in your past, whether you're a student now or a practicing audiologist, how big of a role your previous clinical preceptors have played in your education. I know, for me, I try to take a small piece of whatever clinical preceptor I have at that moment with me moving forward, whether it be how I counsel patients, whether it be how I take an approach in terms of practicing, whether I'm programming a cochlear implant, or I'm programming a hearing aid. You take certain styles and things from every clinical preceptor you have. I don't think this role of the clinical preceptor in a student's clinical education should be understated or undervalued.

You have an immense impact on the students that you work with. So think about how impactful and how meaningful every day is when you are supervising a student. They

take that with them for the rest of their careers 'cause, ultimately, you're responsible for the development of their professional attitudes, their skills, and, to a certain extent, their morals as a professional. And that's why I think it's extremely useful for clinical supervisors to meet with students at the start of clinical rotations to discuss things like their previous clinical experience, what they wanna learn that semester, what they already know, what their goals are, and their expectations of one another as well. Discussions about how to prepare for prejudice or incidents that are a bit uncomfortable should be included in this.

And it might be difficult to initiate, but, ultimately, a way of doing this is by bringing up something like, "What previous clinical experiences have you had in the past with patients that have been negative or made you feel uncomfortable? Do you mind telling me a little bit more about those? That way I can best support you and know what role I can play in terms of helping address that language or that behavior if we encounter it." And ultimately, by asking a student that, they might feel a bit more open or comfortable talking to you about their negative experience that they have had in the past, and this is especially useful when working with students of color.

'Cause ultimately, as Shade has went over in the previous slides, their experiences even clinically are gonna be different than those who might have a more homogenous or identity that might not necessarily be as marginalized as the one of that student. So what are some additional points to also talk about in this meeting between the clinical preceptor and graduate clinician? So if there is a response chosen that both parties are comfortable with a response, acknowledgement that it's hard to predict when and how acts of discrimination or bias may occur. No one can plan for this 100% foolproof, right? Sometimes you go into an appointment. You're thinking it's gonna be a totally fine appointment, and then something happens. But ultimately, it's important that we acknowledge that we don't know when it's gonna happen.

And also, if we do implement a response, we're not sure if it's gonna be 100% effective. The goal here is that we're trying and we're putting forth the effort to prepare for this in a way in which we both know that if we have to step up to the plate and act on it, we can. I also think it's really important to consider if that student's comfortable intervening themselves. So if it's a minor situation or one that doesn't require a lot of escalation, maybe the Diwa case for example, maybe that student feels comfortable saying something to the patient themselves. And if that's the case, that should be vocalized. But ultimately, the student and the preceptor should both come to agreement that the student's emotional, physical wellbeing are prioritized and their education is valued.

'Cause ultimately, the student's there to learn and the instructor or the supervisor's there to teach them about how to practice clinically and work with patients. So ensuring that it's a healthy productive environment is critical here. And also, it's important that everything happens with urgency. Leaving things on the back burner will ultimately create a more negative working environment, and we need to ensure the safety of everyone involved, which is why conversations like this are very important. So what are some other methods to prepare for prejudice? So one is continued education on cultural sensitivity and multiculturalism. I'm gonna guess that's why a lot of you are here today. But as we consider how increasingly diverse our population is getting, that's also gonna include the workforce.

Although it's a bit different in terms of the field of audiology, we can also assume that our patient load's gonna grow increasingly diverse. And there are various educational tools that can be utilized to help us better work with both patients from diverse backgrounds and also supervising students from diverse backgrounds. And that includes various DEI training tools. DEI stands for diversity, equity, and inclusion. Tools such as implicit bias training modules, simulated virtual patients, and this one can be especially useful when considering the learning environment that's provided. So let's

say you're given a case similar to Diwa's. It allows the learner to think through the case without real time pressures of knowing what to say exactly in the moment to that patient.

It allows for them to interact with their peers to discuss potential interventions, what might work best in this intervention, what didn't work great in that intervention. And also, it allows for feedback from the instructors of what could work and why didn't that work. And also, it's really easy to craft those to be very clinically applicable. So that's why I think, especially when you consider continued education on cultural sensitivity, especially in a field like audiology or medicine, simulated virtual patients is especially useful. And these educational tools have actually been shown to have a positive effect on reducing biases that contribute to healthcare disparities. So there's research to back up that this might actually be very beneficial in terms of helping clinicians become more versed in practicing with patients and students from diverse backgrounds.

As Shade mentioned, those with marginalized identities might feel as if they need to conceal various parts of what makes them them to not or to avoid incidents of discrimination or to avoid being the recipient of various acts of harassment, discrimination, and violence. But although this might reduce immediate stress in that environment, it can ultimately lead to increased anxiety, increased depression, and burnout. And I also think at the heart of all this is that no one should have to hide their authentic selves. We all should be able to be who we are both at work and outside of work. And I also wanna bring forth this other point of it is never the job of someone who has a marginalized identity to educate another person on how to be more comfortable around it.

It's your job as a peer of someone who might have a different identity than you to do your research and find a way to make that person feel accepted in their environment that you guys are sharing to work in, and, ultimately, to make them feel as if you belong

here. I see you as a coworker. Whatever we can to foster a productive environment, that way you feel safe and not have to fear any form of violence or harassment based on who you are. You should do that research. It's not the job of the person with the marginalized identity to do that. Again, it's really hard to know how exactly to respond to prejudice in real time.

It's gonna be a challenge even after various amounts of training. But, ultimately, the goal here is that you're putting forth the effort in trying to reduce patient bigotry if you experience it. And oftentimes it's difficult to implement it in real time response, but also it's important to consider responses that aren't necessarily able to be implemented right in the moment, and that includes being familiar with grievance procedures. So grievance procedures are gonna be different if you're in a university setting versus a hospital setting, but knowing how that documentation system works is really important to document various forms of harassment from both patients and fellow employees. So it's really important that if you're not familiar with these procedures, that you report to someone who is familiar or you know someone who is very familiar with these procedures.

I think it's also really important to consider the grievance procedures of national organizations such as ASHA and AAA. I do want to say there are limitations to this, especially if you're looking for a timely solution. And often, these limitations include an arduous or rigorous, lengthy process of reporting it. Having to supplement document materials, and having to attend hearings, things like that can make this a bit more lengthy. So if you're looking for a more timely solution, this might not be the best route for you. But if after consulting with these organizations, you feel as if that case could be productive, taking that avenue, I recommend you do that. So now I wanna go over some strategies that you can use in real time when working with patients, whether you have a student with you.

Some are a bit more applicable of when you have a student with you, but also ones that you can implement alone. So the first is redirecting responses. And this response is designed to redirect unwanted patient behavior to the care that's being provided to the patient. So an example of this is, "I would like us to focus on today's appointment. What are your goals that we can work on addressing today?" So again, the goal of this is to kind of redirect the patient back to why we're all there, which is to provide them care. So whatever the patient was saying, whatever language or whatever spiel they were talking about, if it's offensive, ultimately asking this question, you're interrupting it, stopping whatever they were talking about, and rerouting them back to what really matters here.

What matters here is that we have a productive appointment addressing your goals. And similarly, for the second point, "I wanna make sure we best utilize today's appointment time to best address your hearing and communication goals. What concerns do you have?" So very similar, redirecting that patient back to how can we best use our time today to make sure that we are addressing all your concerns. And this is a similar response that Diwa's supervisor utilize in that case study, but I do want to say that this requires follow-up discussion. So if it turns out that that patient or, I'm sorry, that supervisor or that student was on the receiving end of remark right before this, it's important that you have a follow-up discussion with the student about what happened, and make sure that they're doing okay.

'Cause oftentimes, it's very easy for students to not show how they're really feeling, especially when it comes to being in clinic and things become a bit more fast-paced, It's hard to sometimes really talk about how you're feeling in that moment. And ultimately, with time, sometimes things get lost, and lost in terms of follow-up. So the next response strategy is direct approach responses. And this one's a bit more aggressive in its approach 'cause it typically directly labels the patient behavior. And oftentimes I think this is the one that clinicians feel the most uncomfortable utilizing,

but I think it's really important to consider the context in which you might utilize them 'cause, usually, they are cases where the language or the behavior has escalated, or it's a bit more explicit, or a bit more aggressive from the patient.

And when it becomes a safety concern, sometimes there's no other response than directly confronting the patient. So what are some examples of this? "So we have a strict policy prohibiting the behavior you just showed. If you continue, I will have to have to end our appointment." Another one is, "Are you discriminating against a student clinician based on their identity?" A lot of the times, confronting a patient like this is gonna make them feel uncomfortable. They might backpedal and apologize for the behavior. Or if they escalate it, you might have to consider other things as if getting emergency help. Either way, Sometimes if the behavior warrants a response that's direct and a bit more aggressive, sometimes it's the only avenue for you to take.

I also think it's important to consider other direct approach responses that might not necessarily be real time as well, such as reporting that patient and their behavior to administration or transferring that patient to another institution. If it gets to that level, you might have to ban that patient from your clinic because it might be a fear of safety. It might be a thing that it's compromising other people's health around them. So I think it's really important to consider this and have this in your toolkit as well. So the next is particularly useful for working with students' reaffirmative responses 'cause this response strategy is used to deter further unwanted behavior and also reaffirm the involved clinician's skills or clinical competence.

So what are our examples of this? "So I have no doubt that this student clinician can provide you with the highest standard of quality care today." Another is that "This is a learning facility where students work directly alongside clinicians as part of their training. Let me know if that's gonna be an issue for you." This is especially useful when working with students because, one, it's gonna redirect the patient back to the

patient care, but also, simultaneously, it's gonna let that student know that, "Hey, I trust you. I know that you have what it takes to work with this patient." And it also relays that to the patient themselves. So this is a way of making that student feel as if they're valued and their learning opportunity is valued in this situation, but also telling the patient that we're in a learning facility.

And ultimately, by working with this student, I'm doing my due diligence as their teacher to provide them quality education and also provide you quality care. And a lot of times, this patient will be comforted by this. They'll be like, "Oh, so if the student... The student is good and this instructor values them, and they see them as a team member. Maybe I should also trust working with this student as well." And ultimately, I think it's really important that regardless of any of these response strategies that following an incident of discrimination bias or prejudice that we depersonalize the event for everyone involved. And I particularly mean this with the clinicians. I think it's very easy that, even if we purposely say, "I'm not gonna let what that patient said to me affect me," sometimes it's really easy to go home and be stressed out by that unconsciously.

It's very easy to go home and let negativity get ahold of us. It's sometimes hard to leave things at work, but it's important to understand that it's a reflection of the patient's values and their mindset more than of your skills as the clinician or the student skills as the clinician. So keep that in mind. All right, so our last response strategy is rapport building responses. And ultimately, this response strategy explores the patient's demonstrated behavior in more depth. And this can be utilized to highlight how that behavior the patient's demonstrating is completely irrelevant to the care being provided. So what are examples? "So may I ask why that makes you concerned about the care we're providing you?

" "Why is it that you think that? Can you tell me a little bit more about what you mean?" Or, "I assure you that none will hinder us from providing you with the best standard of care." 'Cause, ultimately, what this is gonna do, it's gonna allow you a little bit more room to get more feedback from that patient of why are you concerned about this or that? And maybe it gives you a little bit more room to address why they're concerned. What is their mind set at? And it also can allow you to redirect the patient or use a similar or a different response strategy to lead to a more productive appointment. And also, it can build a better relationship with the patient, depending on the context of course, but it allows you to explore that demonstrated behavior in a bit more depth involving the patient.

I also think it's really important to consider local resources, especially for students practicing, as well as... I think it's really important that clinical supervisors, as well as faculty and staff of AuD programs be familiar with organizations or resources around them that can support students as well as ways to support themselves. So for this slide particularly, I want to focus a little bit more on the student side of things, but I think it's really important for student clinicians to be familiar with the following resources. So depending on the level of escalation or the extremity of the case, it might be useful to consult with student local services if the case requires it. It's really important to know that you have that in your toolbox if you need to utilize that.

Another one I think that's really useful for everyone involved are offices of diversity, equity, and inclusion. A lot of times, they know a lot of good educational tools that you can use for training. They know a lot about student organizations that can help that student feel a bit more supported on campus. I think it's really easy for a lot of AuD students to feel disconnected from the rest of their university. A lot of times it's, "I go to clinic and then I go to class," and then it's a repeat cycle. You don't really interact with those outside of your program. So I think it's really easy not to be familiar with resources on campus that can be of great help.

I also think mental health in AuD programs is something that should get a bit more awareness. I think, coming from a four-year undergraduate program to a four-year doctoral program, you get so busy that you lose track of your own personal health, or things that, or self-care for a lack of a better word. I think it's really easy to get lost and not pay attention to your basic needs. And I think AuD programs should do a bit more in terms of supporting their students and their mental health because it's a stressful program. It's a doctoral program, students, their life becomes audiology for four years, and it's not just an eight to five. It's an eight to five clinically, and then it can also be class for three hours, and then studying, and then there's comprehensive exams.

It's really important to remember that these students work hard and they're struggling. So making sure they feel supported is a key and a critical part of all this. I also think it's really important to remember that a lot of times AuD programs aren't always 100% informed of the clinical experiences their students are having out there. If they're having a hard time at a certain clinical rotation or if that student's having a hard time, working with patients and being on the receiving end of discrimination, it's important that AuD programs are informed about those things. And lastly, I wanna end by saying that a lot of responsibility is placed on the clinical supervisor, but it's also the student's responsibility to meet the preceptor halfway throughout this entire process.

For there to be productive conversations, sometimes you have to be uncomfortable and have these conversations about sensitive topics. But, ultimately, the more open and honest we are, with our communication, and talking about things that have affected us in the past, and how we can move forward is a critical part of all this. I wanna thank you all for your time, and I hope that you can take a piece of knowledge away from this and apply it in your everyday clinical situation. And we'd be happy to have any comments, questions, or concerns in the chat. And we would look forward to

answering those. Yeah, absolutely. We'll go to questions in just a moment. I'm so sorry. I'm not sure how it happened, but I actually skipped a slide.

There were just a couple of other things I wanted to just real briefly mention. One of the focuses of my work is how we have diverse clinicians in our field and how that affects the patients that we actually get. We do find that a lot of research has shown that a lot of patients prefer to see clinicians with diverse racial, ethnic, LGBTQ+, and other identities that match theirs. If someone has a historically marginalized identity, a lot of times people like that, including myself, prefer to see clinicians that they know will be able to interact with them effectively and confidently. If you do have a diverse clinician or student, then it could actually even open up patient populations.

They would be more willing to work with that clinician. It could even open up new opportunities for your business. We also know, I just wanted to briefly mention, that the absolute number and the proportion of older adults in America, like I'm sure you've heard, it's increasing and that's going to increase demand for audiology. And already, there's been a fair bit of research that shows there isn't enough audiologists currently practicing for the need, and that's probably going to continue for a long time. It's important to understand and respond appropriately to when our students have these experiences of harassment or prejudice. Because if we're driving these students out of audiology by not responding appropriately when they have these experiences, not only does it provides a barrier for other people with diverse identities, getting the care that they need, and being willing to pursue that care, but it also worsens the lack of audiologists.

And I just wanted to just very briefly mention that. Very sorry. I do notice we have a few questions that came in. We'll take just a couple minutes to answer them. There's a question about, "I'm sorry for being so ignorant, but can you explain your descriptions of what they mean? What does it mean to be asexual, non-binary, and cisgendered? I

don't know what these terms or even how I would describe myself." That's a really great question. It's important to understand these terms because our patients use them. They're more active in the news cycles, and many states are starting to pass policies that affect how we interact with patients that have these identities. So the LGBTQ+ label, I like to think of it as an umbrella term, covers LGBTQ identities, but it covers over other identities too.

It's really kind of a catchall for anyone who has asexual orientation or gender identity that just isn't cis or hetero. Heterosexuality, just being attracted to someone of the opposite gender. And being cisgender just means that when you are assigned a gender at birth based on your anatomy, that's the one you identify as. The gender that you identify as matches what you were assigned. And we can kinda contrast that with people who are transgender. They're just not the same gender that they were assigned when they were born. And personally, I'm non-binary. I don't identify as a man or a woman. I'm not male or female, and that's why I use those they/them pronouns. So if you ever have someone, a patient or a clinician, that uses they/them pronouns or mentions if they're non-binary, then they're probably just saying that so you know how to refer to them correctly.

You can say things like, "I know them. They are a great clinician. I'm going to get their report in a few days." We can use those terms to refer to people correctly, and that's why sometimes it's kind of inevitable to have those conversations. Someone can't refer to you correctly in conversation if you don't mention it. So that's just what I mentioned that. When I mentioned asexual, I think most of us are familiar with identities like being gay or lesbian, being attracted to the same gender you identify as. Some people are attracted to several genders, like if you're bisexual. Some people aren't really attracted to anybody. It's called being asexual, and it's just another term under that LGBTQ+ umbrella.

I hope that answered your question. That's a really great question. If you have any others, please feel free to drop 'em in chat. I noticed another question. "I've also experienced being blonde, and female, and being a Christian, and people make preconceived judgements." That's totally true. In our American context here, we usually think about being Christian as being the dominant religious identity, but that's not always true, and it depends on the region you're in. And there's also many different sex of Christianity, and we need to be aware of these things, and we need to be open and talk about these things. They can also be a source of these negative interactions, and it's okay to acknowledge that.

It's okay to recognize that there's differences between us, and that they can cause conflict so that we can think about how we can have a mature, reasonable discussion about how we can move forward despite these differences. Thank you for bringing that up. Absolutely. I'm gonna give you just another few seconds if you have any final questions. Otherwise, thank you so much for joining us. I hope it's been helpful. A lot of this is an ongoing conversation to have with your colleagues, with your students, with your staff. If you have any other questions, drop 'em in chat, otherwise... I have one final, question. Thank you so much. You're welcome. Thank you so much for joining. Okay. We'll go ahead and wrap up here.

Thank you so much for joining us. I hope it was helpful. Y'all have a good day.