eAudiology: Join the Discussion: Moving from Microaggressions to Cultural Humility: A Critical Discussion for Audiology - Part 1 of 4

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I'm Erika Friedland. I am the chair of the Academic Programs Committee for the American Academy of Audiology. I'm going to in just a little bit introduce Katie Colella, who was the previous chair, who started the work that we're continuing with this committee. Today is part one of our four part series Moving from Aggressions to Cultural A Critical Discussion for Audiology. Our next part in the series, they haven't yet been scheduled but we're aiming for June, early July and August, early September.

But our final one is definitely scheduled at this time for October. So we're looking to have these conversations over the summer and finishing up in October. You'll see those announcements coming through the American Academy of Audiology through their email blasts and on the website. Today is a continuation of the Clinical Education Forum that the committee presented at the conference just a few weeks ago.

At that forum we were discussing clinical microaggressions and basically ways in which to best deal with them and sharing with our participants tools to use. We followed up or concurrently I guess you could say. Our work was also in a poster that I'll also share with everybody today too. So if you could turn to the next slide so we can just look at our objectives for today's discussion. We're going to talk about different kinds of microaggressions that occur in really just clinical practice, but also in education, explain the concept of Cultural Humility framework and talk about some strategies for addressing microaggressions directly.

So today I have a panel with me of Katie Colella that would be the next slide. Katie Colella and Ale Abdel Hakim and Lachelle Lazarus. So let me just tell you a little bit about today's participants. Katie graduated with her A.U.D from Purdue University and she started her career at Mott Children's Hospital at the University of Michigan before joining the Anne and Robert H. Lurie Children's Hospital in Chicago and she's been there since 2016.

She's a member of the Diagnostic and Inpatient team. She sees patients for diagnostic evaluations, electrophysiology, amplification, fitting and management. She's co authored multiple articles about avoiding microaggressions in audiology and co created a self study continuing education course titled Toward Cultural the Black American Experience. She's the previous chair of the Academic Programs Committee and she's a member of the Guidelines and Strategic Documents Committee of the American Academy of Audiology. She's also the creator of the podcast miniseries called Amplified presented by Lurie Children's hospital.

The next one on our panel today is Dr. Ale Abdel Hakim. She's a clinical assistant professor at the University of Texas at El Paso School of Pharmacy. She received her Bachelor of Chemistry degree from Missouri State University and then her Doctor of Pharmacy degree from the University of Missouri Kansas Kansas City School of Pharmacy. After completing her studies, she went on to complete residency and fellowship training.

Her research interests include cultural competency, diversity, equity, inclusion in academia and in health care, student wellness and resilience, and health disparities. And our final panelist for today is Lachelle Lazarus. She's an audiologist at the University of Maryland Medical center in Baltimore, Maryland. She specializes in tinnitus assessment and management and vestibular diagnostics. In addition to her clinical work, she precepts doctoral audiology students that are both interns and externs.

She completed her fourth year externship at Yale University in New Haven, Connecticut and she's just recently elected as a board member of the American Academy of Audiology. She's also a member of the American Academy of Audiology and is currently the chair of the Inclusion Representation and Equity Committee. She has other interests outside patient care, supervising and mentoring students and new graduates, helping them navigate entry into their careers. So welcome to all of our panelists today. I think that you'll find them very, very knowledgeable and very well qualified to be able to talk on

this subject.

I do want to share with you, Kathleen, if you'll just let me share my screen. Excellent. So, just wanted to give you a. Oops, of course. Hang on just a second.

There we go. Just give you a view of the poster that we presented, primarily because it has the tools on it that we're going to be talking to about today. Specifically the first one, the Overland et al tool. And these are in the research that the committee did. These were the six tools that we found that were current, had really excellent applicability in terms of how to deal with microaggressions, especially in the clinical setting, and were pretty easy to fit into almost any framework.

We did take a poll at the very end of our forum to find out which people thought were the most useful. And that was the Overland et al. That was written specifically for medicine and it really gives a nice step by step way to directly address the comments. So this poster, this can be made available. We can certainly send it to anyone that wishes to receive it to have more information or just to be able to kind of implement it in their clinical practice without saying any more.

I'm going to introduce Katie, who will be speaking Next. Thank you, Erica. I am going to share my screen.

Katie, while you're doing that, I did forget to tell the audience one thing. Captioning is available so you just have to enable the button at the bottom of your screen. There is a live transcript captioning. Okay. Oh, thank you.

Okay. So like Erica said before, I was the previous chair of the Academic Programs Committee and I was fortunate that in about fall of 2019, the board decided to start a subcommittee called the Cultural and Linguistic Diversity Committee and asked if the Academics Programs Committee would take that

on. And so we did and decided that our first task would be creating a poster for AAA 2020 about the topics we felt were most important to this, to this topic and would be most useful for audiologists. And so I'm sharing the 2020 poster which unfortunately nobody saw in person due to, due to the conference being canceled. But luckily they did still have a virtual poster conference that year.

And so we had three different topics we touched on. And as you can see in the middle, one of them was avoiding microaggressions that year. And then the committee, the subcommittee, we then authored a article for Audiology Today that was based off the poster to put it out there and actually get a lot more talk a lot more about the tools that we'll be talking about today.

And then we, the committee got asked to co author a two part article series for the hearing journal. And so the first one was specifically about avoiding microaggressions. And then we did another one about promoting health literacy a month later. So that was April and May 2021.

And then this will come up later, especially in our fourth, in the fourth webinar of this series. But my colleague Suzanne Pak and I created a CEU event. This was just specifically for Lurie Children's called Towards Cultural Humility, the Black American Experience, which had four different CU opportunities. They were broken up into these four chapters. So you could, it's a self study so you could do it at any pace.

You could actually do the chapters in any order. You didn't have to go one through four. So this Juneteenth will be its one year anniversary of when that was released. And so Suzanne and I will be speaking about that for the fourth webinar.

And I just wanted to include this slide. I did not create this slide. This is created by Leanna W. Lewis, who's a social worker at ucsf. But this was.

We talk about cultural humility. That term was created in 1998. It was coined by Dr. Murray Garcia and Dr. Tervalon There are two physicians who came up with this idea of what's the difference between cultural competency versus cultural humility and how.

I think a lot of times cultural humility is the goal for many of us, to be better clinicians. Erica, would you like me to pass it back to you? Sure. Thank you. Katie, Let me share my screen in the fourth part of this series.

I believe your colleague Suzanne Pak and you will be together in October. Yes. Correct. Excellent. Now I have the pleasure of reintroducing Dr.

Ale Abdel Hakim. She's going to talk about microaggressions and give an abbreviated version of the presentation that she gave at the Clinical Education Forum. Thank you, Erica, for the introduction. So I'll go ahead and share my screen really quick. Oh, sorry.

Let me redo that.

Sorry, I'm having some issues. Give me one second.

So I think we were going to start while you're working on that, Dr. Abdel Hakim, with one of our polls. If either Sarah or Kathleen can put up our first poll. Oh, there they are. Yeah, perfect.

Okay, I got it. Can you guys see my slides? Okay. We can. Okay, perfect.

So, like Erica had mentioned, I'm going to give a quick kind of overview about microaggressions. So I'll talk about kind of what it is and be able to give some examples from there.

What are microaggressions? Feel free for the audience members if you want to use the chat. You let us know what your thoughts are on microaggressions. But really microaggressions, they're very subtle in nature and they can be against or towards marginalized groups of people or individuals. I'll talk more about it on the next slide.

Again, feel free to use the chat for you know what microaggressions is to you. And so you'll see here that I've divided up the term microaggressions. I think it's always important with any terminology to kind of break up the part and kind of see what its true meaning is. So you'll see the first part is micro. And so this is really referring to the interpersonal acts of the microaggressions.

And then you'll see aggressions, which is really the harmful behavior of the microaggressions. Dr. Darrell Wing Su, he's an American psychologist. He's very well known when it comes to his work on microaggressions. He had a really good definition and he mentioned that microaggressions are brief and commonplace.

Daily verbal, behavioral and environmental Indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights or insults. So there's really two things I want you guys to pay attention when it comes to this definition. The first is highlighted in red, right? So that microaggressions, it's important to know that they can be intentional and they can also be unintentional, right? So it's not just an action that is done intentionally.

It can actually be done when someone is unaware that they're actually performing a microaggression. That's very important to know. The second thing that I want to point out is that microaggressions are not only verbal, but they can also be behavioral. And there can also be environmental microaggressions. So it's not just limited to what we say.

It's also can be performed in different ways. And we'll kind of talk about that in the next slide. So as you see, I've divided, you know, the type regressions, so we have our verbal. So this one's kind of obvious, right? So it's comments or questions.

An individual, individual or a group of marginalized people. And so an example of this would be, you know, an individual saying, you know, you're so smart for a woman. Right? So that statement, although maybe they. That individual thinks that it's a compliment, it can actually be very hurtful.

And you can kind of see that this may or may not be intentional, right? So it could come from an unintentional place, or it could be intentional. Right. That they're trying to kind of cause that harm. Next, we have behavioral or nonverbal types of microaggressions.

So this is discriminatory behavior or otherwise hurtful behavior, again, to a marginalized person or a group. And so the example I have here is an individual deciding to sit next to a white individual rather than maybe a black or Hispanic. Right. Someone from a marginalized group due to fear. Again, it's not verbal.

They didn't directly say anything, but by that kind of indirect action, it is considered a microaggression. And then lastly, we have environmental microaggressions. And these are subtle discrimination that occurs on a larger scale within society. An example would be that upon visiting a college campus, you notice that all the building names are after white individuals. What does that say to the students or faculty that are a part of that college or university?

It can be harmful to them at that level. Moving on, you can actually further classify microaggressions. We have this. We discussed the definition of microaggressions that we can actually further classify it. You see, we have microinvalidations, microinsults, and then micro assaults.

You'll see the arrow and it's showing you the varying degrees of, you know, it being unconscious, covert, unintentional to the conscious over an intentional action of an individual. So we'll start out with microinvalidation. So oftentimes this is, you know, unintentional. So an individual saying, you know, racism does not exist in today's society, or I don't see color. So you can see that maybe the person's coming from a good place, right?

They're not intentionally trying to harm any individual or groups of individuals. But what it really the statement does is that it's denies what the person that's on the receiving end has experienced and their culture and all the maybe hardships they've had. By hearing this statement, you can see how that can be hurtful. Next we have micro insult. An example would be, your people must be so proud.

Someone can take that in a negative way. Then lastly, micro assaults an individual saying, your kind does not understand English. You can see this phrase is a bit more intentional. You can tell it's meant to hurt that individual, that this is being said to ultimately repeated and targeted microaggressions. As this continues on, it leads to microbullying.

Microbullying is just that repeated action of these microaggressions, and it's very harmful ultimately to that individual at a different level, psychologically, physically, whatever that may be for them. The next thing that we want to ask is, why do microaggressions occur? We talked about the different types. We've talked about how it can be intentional, unintentional. But oftentimes these are really occurring from biases that we have that are associated with race, gender, and sexual orientation.

And the list goes on. Right? There can be a lot of different types of biases, and it's not only at an individual, but it's also at an institutional and societal level. We talked about how microaggressions are invisible, they're unintentional, and they're subtle in nature. And then lastly, no one is immune from inheriting biases, right?

Which puts us at risk for saying microaggressions or even being at the receiving end. So it's important to identify that. Moving on to the significance of microaggressions, microaggressions, we discussed how it can be very harmful to patients, students, any individual, really. That's on the other side of the microaggressions. And I've listed some examples on the slide.

It can also be harmful to health care providers that are also at that end of the microaggression. But ultimately the microaggressions can also affect access to power, resources and opportunity of individuals. And it also contributes to the persistent disparities that we see. This really great quote I wanted to make sure to include by Dr. Darrell Wang Su, which I had mentioned was the American psychologist.

He mentioned microaggressions are similar to carbon monoxide, invisible but potentially lethal. Continuous exposure to these types of interactions can be a sort of death by 1000 cuts to the victim. I think it's such a powerful quote that really explains the effects that microaggressions can have, despite, you know, it being so subtle. I did also just want to point out that, you know, there are some dilemmas in recognition and response to microaggressions. And I won't go through these in depth, but I wanted to list kind of the three main ones.

So the first is the invisibility of the unintentional bias, right? It can be invented, it can be unintentional, but again, it's very subtle. It's indirect. So oftentimes it's hard to recognize that a microaggression even occurred. The second would be perceived minimal harm of microaggressions.

The microaggressor oftentimes believe that they didn't really do anything harmful. If they're not able to be aware of their action, it's hard to correct that behavior. Then lastly, the catch 22 of responding to microaggressions. Again, just determining if a microaggression occurred, and then once you determine that, determining how to respond can oftentimes be tough as well.

I just wanted to include this slide to show you that microaggressions, again, no one is immune. And it really is not limited to someone that's in a lower power. It can really be can happen to anybody. You can see that microaggressions can happen from providers, against patients, against students, trainees. It can also be the other way where students and trainees can have microaggressions against providers.

You'll see, again, it's not no one is immune. And it can also occur, you know, among interprofessional teams and also at a systemic level. And so with that, I know we have two poll questions. I'm not sure if you guys were able to answer the first one, but if not, we'll go ahead and do those poll questions now.

So we'll give you just about 30, 45 seconds to answer. This one should be fairly easy to answer. We wanted to be sure to put unsure in there. So, wow, eight out of eight. So that's of course very upsetting but not unexpected.

Right. And then we have another poll question for you.

And this has to do with strategies on how to deal with microaggressions. Maybe you don't have sort of a formal framework, but you have some familiarity or you've had to institute some something in the past. Okay, well that's great then. This is really, really good. Not that you don't know how to deal with them, but that we've got this captive audience because I would love to send you all the poster so that you have some of the framework.

But that's really something that Michelle is going to talk about more in depth. She's going to talk about just some personal examples of microaggressions and then sort of application of strategy with these examples of how you kind of solve. Well, we're not going to solve a lot of problems, but how do you respond to these microaggressions? So, Lachelle, excellent talking about some personal examples of microaggressions. I have experienced numerous occurrences of microaggressions in my time as both students and as an audiologist.

So I'm going to kind of COVID them briefly here. So one that I have received is, you know, where are you from? And when I say that I'm originally from Toronto, Canada, there's a, you know, where are you really from? This emphasis of, you know, you couldn't possibly just be from there. Where do you actually originate from?

And it's just a question that seems to be directed to myself as a black audiologist and not necessarily to my colleagues. That's always an interesting question that is asked of me. I just respond and say, I'm from Toronto, Canada. You'll get the same answer. Another example is you articulate so well.

I had a patient once who after I finished counseling with that patient, they then proceeded to ask, do you get training on how to speak? And that was a shock. And because I experience these situations very frequently, there typically isn't a like a flinch from me in those situations, but I'm able to just say, no, this is just how I speak. But it's just interesting that when I bring this up with my colleagues, this comment is not often or ever directed to them. So something that I've noticed that can come up numerous times.

You articulate so well.

There was a situation where I was working. This was as a student and a patient that I had worked with who was following up with another audiologist, a white audiologist had said, you know, the little black girl helped me. And that was interesting because one, I would never introduce myself as a little black girl. And it just kind of minimized how I felt in that situation. And you know, it is true in regards to when we experience these microaggressions early on in our career, early on in our education, it can kind of form this mindset.

When someone sees me, they don't see me as Dr. Lazarus first. They see me as a black woman first. Or in this case, this person minimized me to a black girl. So it's something that I keep in mind, unfortunately, that in this society, when I present myself, I'm sure that often that is what is seen first.

But Lachelle, you're not little, so it's odd. It's such a. Like, it's so purposefully meant to be because you're taller than. Than most females that I know. Exactly.

I am five nine, so I'm nowhere near a little. A little girl.

Another example was when I was talking with a colleague who was recounting a situation with a black patient. And when she was saying what they said, she put on an accent that was very stereotypical of African Americans. And it was. It sounded almost like uneducated. And it was just very disrespectful, in my opinion, because one, when we are telling another colleague about a situation, we never put on an accent to try and perfect, perfectly mimic someone's voice.

And also that's just disrespectful to put on that quote, unquote role of, you know, a black man in that position. So that was very. That was a microaggression, an example of a microaggression that I experienced as well. And then I think that a lot of individuals in audiology can refer. Can relate to this, but being referred to a sweetheart, being referred to chick.

I had a patient who. And I was with my student, my extern, and we were doing a vestibular eval, and he said, this is so great. I got two chicks with me and continue to talk and we'll talk about the strategies that we use in regards to those situations because that's unfortunate that we are put in a position where these microaggressions often occur. And especially for that last one, I'm sure a lot of us can relate to it. So in this article, the Microaggression in Clinical Training and Practice by Overland et al.

There is a three step approach that we want to use when we're addressing microaggressions. Now, the first step that we want to use is to prepare. So we want to have open ended questions on the preference of how we want to address microaggressions. We want to reflect on the situations where a direct response may not be the best option. So actually thinking about hypothetical things that could happen and then what would be the best option in that situation.

We also want to share personal experiences. It's from our personal experiences that we can develop some kind of protocol of how we want to move forward. That means we're making explicit plans on how to respond. Not just vague ideas, but actual explicit plans on how to respond. So how do we respond right in the situation?

This approach was outlined in the poster that was presented and we're going to touch on that. So when there's a microaggression that happens, we first want to address the comment. We want to name the behavior as inappropriate, essentially saying, I'm surprised that you thought that would be an appropriate comment or joke. Basically naming the behavior and that can be uncomfortable, but it's something that has to be done. Then we want to refocus the conversation on the patient's health.

We want to essentially tell the patient, I'm here to discuss your health. I can't discuss that with you. I'm here to discuss your health. Then share your perspective. When you called me a little black girl, that made me feel disrespected or that made me feel small.

Sharing your perspective on how you feel, that can be hard for us to share that. But it's necessary in order for that individual to learn how their words can affect us and then remind the patient of roles. So after we say, you know, that made me feel a little small. I am the doctor of audiology, I'm here to help you with your hearing health. Just kind of putting it back to perspective of this is who I am and this is why we are in this interaction here.

And then temporarily remove the learners from the environment. So even if you have to say, we're just going to remove ourselves from the situation, we're just going to step out for a second and come back to the situation. It just gives some air to the situation so that if you need to regroup, you can so that it does not affect the quality of care that you're able to give your patients.

Then lastly, we just want to Reflect. So after experiencing a microaggression, taking the time after that situation to speak with anyone that was involved, whether it be a colleague, a student, and you want to be intentional to spend the time to reflect on the uncomfortable encounter, ignoring, suppressing, laughing off, or minimizing microaggressions is inappropriate. And that can sometimes feel like the easiest thing to do or just the natural thing to do. But if we are engaging in that, then we are not going to move forward in how we deal with it. So, that being said, we're going to move on to our next section.

I'm just going to stop sharing here. So lashelle, one of the attendees, has also had one of the things that happens to you often happen to them. And, you know, she or they just try to say, you know, I'm. This is about asking where they're from. No, where are you really from?

And. And she said, you know, I just say I'm from New York. And so do you have any suggestion, other suggestions that you. You've used to redirect? You know, would you just say, I'm from Toronto, Canada?

As I said, let's get back to what we were talking about. Or was there something else that you or allay that you've used in the past that's worked well for me? Yeah. I just basically repeat it again because it is hard in that situation to say, well, why are you asking me this question? It can set a tone at the beginning of an appointment that you don't want to set with your patient.

I typically have said, nope, I'm from Canada. If anything, I will say, you know, my parents are of Caribbean background, but that's it. And then we just keep going in terms of, as you said, we're just

going to keep going with the appointment. But that's where I'm from. Yeah.

And I agree. I think I approach that situation the same where I can, you know, give the answer and just redirect to the purpose of why we're meeting. So we're not kind of discussing too much of the outside stuff. So I usually redirect back to kind of the focus. I noticed that in a lot of the literature that I read in preparing for the forum, a lot of it came from medicine, and a lot of it uses that redirect technique, telling patients, sir or ma'am, we're here to talk about your discharge instructions, or I'm here to give you specifically medication instructions.

We're not talking about my appearance today. They use a lot of redirecting in those kinds of conversations.

I've been in this profession long enough. I don't think Katie or Lachelle has, but many times, and I know there's probably some people on the audience side who got referred to by the older ent as the girl down the hall. Go and see my girl down the hall. She'll check your hearing. I can't even imagine.

I'm sure it still happens today, no matter how many times we would. Correct. Maybe that's how come I ended up in education, because I was really annoyed at being called the girl down the hall and then constantly correcting ale. I wonder if you want to discuss some of maybe the different kinds of microaggressions you've encountered more than once or that kind of stick out in your mind. Yeah, absolutely.

So I think the biggest thing, you know, I. I have a headscarf, right. And so that kind of gives away my religion and I'm a Muslim. And so I think that's been probably the biggest type where it's like that religious bias where, you know, someone may see me and then they automatically have all these assumptions about who I am or, you know, different things that they. They kind of relate Muslims from what they've heard through the media or just from ignorance.

And so I think that's probably the biggest type of microaggression. And to give you an example, and this one kind of sticks with me. So as a undergrad student at Missouri State University, I was in the honors college. And so I remember, you know, my first day of classes at Missouri State, of course I'm excited. And I had an honors class.

And so I had, you know, went to the building, went into the classroom, took a seat. And with our honors college classes, they're smaller, right? So you're not going to have the 200 student class. You may have 15 or 20. And so I remember I went into the class and there was already a lot of students present, sitting, and I remember everybody just looking at me and just kind of confused, like, what is she doing here?

She probably has the wrong class. She probably doesn't realize this is an honors class. And you can tell by their behavior. So, again. Right.

The behavioral type of. Of microaggression that they felt like I didn't belong in that class, that maybe they were afraid to say something. And so I, you know, I witnessed that. And of course it hurts because what does that tell you? Like, does that mean that anywhere I go, people, you know, assume that I'm not going to be smart or I'm going to you know, be a certain way.

And so I remember just kind of, you know, recognizing that, staying quiet. And then once the faculty or the professor walked in and took attendance and mentioned, you know, called out my name, they kind of like looked at each other like, oh, she is, you know, she is part of this class. And then of course, once I started speaking English, they were also surprised that I speak fluent English. Right. Which is probably another bias that had, they had based on just seeing that I'm probably not American.

Right. So I think that one kind of is a good example of how, you know, our biases can really affect how we see people. How, you know, we make assumptions and even, you know, perform or make microaggressions that either we're intentionally making or unintentionally making. I would say those are the biggest ones. So my race and the religious bias.

How do you think, and this is for anybody, how do you think we become aware of our own unconscious biases? Everybody has them. You're raised in a certain way, you have different environments that you're in, and it all contributes to those biases. So how do you think that we become aware of our own so that we can always be, could always be thinking about it?

I guess I can go ahead. I think the biggest thing that we, you know, like Erica said, we all have biases. Right. It's not something that we can run away from. And I think it's just recognizing and self reflecting.

Right. So paying attention to how you're feeling in different situations, you know, thinking about how you act in those situations, whether it's verbal, non verbal, I think self reflection and education are key. There's no way that you're going to be able to really identify what biases you have without educating yourself and then self reflecting on your behavior, your actions, and your internal thoughts that you have about individuals or groups of marginalized people.

Yeah, I would definitely agree. And I would say monitoring. If you feel like you are approaching individuals differently because you have just read a name on your schedule, or, you know, this person is an African American individual or an Asian individual, you know, just checking to see, am I manipulating how I'm going to approach this patient? Because I put some preconceived ideas of this patient in my mind, I think that's a good way to check it to say, wow, I don't think I'm being as fair or giving as much grace to this individual as I have to someone else. And I think that that can be a great way to kind of self monitor and Say, oh, wow, why am I.

Why did I treat this person like this? That can help with helping us find our biases. I start, oh, go, Katie. You're next. I did a bunch of the implicit bias test when we first started working on this back when I was on the apc, and it's tough to do that and see your results.

But I learned a lot about myself, I think, just moving forward. I work with all pediatrics, so I'm learning to try to be very consistent of how I approach everyone's family and not assuming who any individual is, how anyone's related to anybody. Right. And trying to ask in the same way, even if I feel like this is a slam dunk, this is this child's father, but still making sure I'm verifying. So it's just the same for everyone.

So it's not me making assumptions of who is and who isn't in a certain role with kids. I just wanted to thank the University of Miami for five years, and that's an inner city next to an inner city hospital. And I learned that so quickly. Never make assumptions about who's bringing who to the appointment. So always asking, you know, are you the biological father or, you know, who is the biological father or mother, you know, are you grandmother?

Always asking the question, so you kind of know where. Where you are. I just wanted to relate one thing about education, and that's. I think as educators, we. We develop some biases about students entering our program.

So we see the whole profile, right? We see their gpa, we see the courses that they've taken, we see their. Maybe their test scores. We interviewed them. And so I think, you know, based on, you know, doing this for the past 24 years, we have some preconceived and probably unconscious biases about the students as they enter.

And, you know, I work really hard to just make sure everyone's on a level playing field. And I love it when, you know, students sort of surprise me with things, but. But the surprise means that I still was

holding onto that unconscious bias, not really necessarily bringing it to the forefront. So really continuing to work hard with faculty, like, forget everything, you know about this incoming student. They need to start with a blank slate.

And I wanted to just add one thing. I know Katie mentioned the implicit bias, like the tests out there. I think that's such a great tool. I actually, my first experience exposure was during, as my time as a student, a pharmacy student. We actually had a class just on, you know, implicit bias.

And we all had to take this. The implicit association test. And I think that was very eye opening to what biases I had. So I definitely recommend. It's kind of part of that education piece.

So as educators, or even if you're precepting students, I definitely recommend to give your students the implicit association test and also take it yourself so that you're also more aware of your own biases. I think having that discussion with students ahead of time, early on in the rotation can make a huge difference in how they approach patients for the rest of their career. I think it's important to take that time and maybe have that discussion and let them take that test as well. Have you all had to intervene in an interaction with a student or maybe with a colleague where you've observed a microaggression either occurring or perhaps hopefully not too long after the fact? And what did you do?

I could think of two examples. So one example, one of.

And we were with a patient and the patient, who was a white woman, had a. She brought her, her son with her or her grand, her grandson with her and said, you know, my son. Or she was relating someone to the child. She said, they have hair that is just like yours. And this is while we're just doing, we're presenting the results.

And it was just kind of off putting because we had just counseled on the results. And this was the next thing that she said. So it's almost like she wasn't even listening. She was distracted. And then what she said as well was just inappropriate for the situation because it was not called for in the moment.

I just kind of said, okay, we're going to continue on with this, with this counseling. And then I spoke to the intern after to see how she felt about it, how she would like to respond in those situations and things like that. In the moment. I didn't necessarily correct the patient because again, it is hard to correct someone right away. Even though this is the strategy that we should do, it is easier said than done.

The one example where I did correct the patient in the moment was when I was with another student. And again, the same example of the vestibular patient and he kept kind of referring to us as chicks. He had said, you know, oh, this is great, like two chicks with me, you know, sweetheart. And I had to tell him, I'm so sorry, I'm going to have to ask you to stop making inappropriate comments and we're going to continue with this evaluation. And he stopped.

He did say, you know, I'm just joking. That's just how I joke. Things like that and I wasn't going to push it harder than that, but I just called him out that this is inappropriate and we need to move on. So that was an example when I tried to call it out in the moment.

I can also provide another example. A situation that comes to mind is I actually had a student with me on rotation and we were in a patient's room and they were leading the counseling session with the patient. And I recall that at the time, the patient, when the student introduced himself and the student was a black American and he introduced himself, told him, I'm a fourth year pharmacy student, I'm going to be educating you on your medications. And the patient was just surprised and was like, oh, you're a pharmacy student. Not thinking that a black student can be in a pharmacy program and can be successful or capable of educating the patient on the medications.

I just want to take a step back and tell you guys that the way that I approach my students is I always, again, we talk about microaggressions ahead of time. Before we start rounding, before we start interacting with patients, I always ask them, how would you like me to deal with any microaggressions that may happen to you in that setting? Right. Do you want me to speak up or are you comfortable kind of speaking up and redirecting on your own? So I always try to kind of see the comfort level of the student, how they want me to approach that so I'm not making things worse or embarrassing them or I want to be able to deal with it the way that they would like me to deal with it.

At the time the student had mentioned, I think it's okay, I think I should be able to deal with it. And so of course, at the time, I of course respect that. So I kind of, you know, stay silent. And the student, you know, just redirects, you know, ignores whatever was said and just kind of continues on with the counseling session. And again, different students can respond differently.

But I think it's important to always, you know, if given the opportunity, ask your students how they want you to deal with that situation. I really like that you have that conversation with your students. I'm going to start doing that with all my students. I think that's great. The situation I had was I was working on a Saturday and the clinics, it's a lot slower on a Saturday.

I had a patient who hadn't shown up yet, which was unusual. And I walked past the check in area by chance and saw my patient and her mother just sitting in the waiting room. And so I went to the individual working check in and said, you know, why didn't you. That's my patient, you know, why didn't you check them in? And her response was, oh, I couldn't really understand her.

I thought she was going.

She had an appointment elsewhere. So I had to go back there. And so instead of helping this family, they had just dismissed them. And unfortunately, this individual just didn't think. Just thought it was their

fault that she couldn't understand them.

And so the way I approach it, I just told the check in person, finish this check in, do this check in now, because I'm going to see them. And I just kept. I just apologized to the mother and the patient and then I did bring it to the manager though, of that individual. I did not let it go. And so I know the manager followed up with her and followed up with me.

That person does not work there anymore. Not because of that situation. She was nearing retirement. But I just tried to put the focus on making sure that the patient and the mother were felt understood as best as I can do it, and let them know that I was going to still see them because they were late, but they weren't really late. So that was how I dealt with that.

I have a question for the panel from one of our attendees. So they have. One of our attendees has a colleague who uses the approach that we should call people in instead of calling them out when a microaggression is made. So anybody have any thoughts on that approach? I think the semantics are really nice because kind of calling people in implies that you want to have a conversation with them about what's going on.

Calling them out always sort of has a bad connotation. Right. And not that you would want to minimize what they've done, but it seems like it's a little bit of an invitation. And so that's kind of a. Kind of an interesting place to be.

Anybody have any thoughts on that? And while you three are thinking, I just want to let the attendees know that I put the link for the. It's the Harvard implicit. It's called Project Implicit. And there's many different types of implicit bias tests within that Harvard Project Implicit.

And you can choose which ones you want to take. You just have to agree that the data you provide in taking the test can be used in their research. And so that's where you just click the button at the bottom signifying that you'd like to proceed. I took it back probably when Katie took it, about a year and a half or so. Ago.

And I thought, no way. I'm not biased. And it was a little bit eye opening and somewhat disturbed to see the results. You know, I thought I was. Part of it's about speed, and part of it's about the way you respond.

And, you know, you. You have a picture of yourself in one way, and then what came out on the. This test is just one way to have some feedback that, you know, you're always a work in progress on this. It takes a long time. I know.

I was in Portland last week for the capsid conference. And Portland, especially downtown, has a very significant problem with homeless population right now. The housing costs have skyrocketed, and there's just a lot of homeless people everywhere. We encountered one in the restaurant that we were eating in. She had just walked in off the street, sat down, and I think she must have been known to the management because she just started spewing all kinds of things.

And she clearly knew the buzzwords to get people to back off of her. But I was impressed with how the management kind of dealt with it. I heard them call the police right away, but there were two security people, and they really weren't engaging with her other than to make sure that she wasn't engaging with people that were in the restaurant. But I felt like it could have so easily gone downhill with the way that they responded to her and the things that she was saying. So, you know, just.

It just, you know, it seems like you just encounter it in all sorts of interactions. I had a. We had another attendee share a situation that there was. And this was with a colleague during holiday time. The

department door was decorated with Christmas stockings.

And a colleague of this individual ate a banana and then put the peel into this person's stocking. And this person called the other individual out right away and explained that the behavior, though didn't seem intentional, was completely inappropriate. This person is the only black audiologist in the department. And you picked my stocking to put a banana peel in. And she said that the person apologized for days, but that calling the person out was really important.

And so I, you know, I asked her, has he ever done anything else? And she said, not that severe, which means that he has done other things, just nothing that rises to that level. So I'm sorry that you have to. That you have to deal with that. And hopefully, although not really your job, hopefully you can help this person make some advances by teaching and modeling.

Okay, let's see. Were there any situations that you were in where you were sort of maybe a bystander, and you observed a microaggression occurring. And, you know, did you or didn't you say anything?

Before we get to that question, I want to answer the calling in, calling out. Okay. Yes. I think that it does depend on what the statement is said, how it is said. Some people are more intentional than others.

I think you can read it to a degree, but if something is inappropriate, it's inappropriate. I think that calling in does sound better in regards to we're inviting you in to understand, even if you're calling out someone, it doesn't necessarily mean it's in a conflict approach. You can call out someone in a very respectful approach, which is what we all should strive to do. And in calling out, even though we're being direct, we are actually giving them information. So if you want to think of calling in as I'm providing you with information so that you understand, although we are different, we are equal or equity and things like that, but calling out is still very necessary.

It's how you do it that will influence how that individual moves forward. So that's what I wanted to say for that. Great response. Lashelle Ale, did you want to say something? Yeah.

No. I completely agree with Lachelle, and I think it's important to kind of recognize that, you know, if you decide to stay silent, which, you know, it's up to you kind of how to respond. The only downside to that is that you're not. You're not preventing this from happening to other people or in other situations. And so I think, like Lachelle was saying, sometimes it is appropriate to call people out in a respectful manner, to kind of make them recognize, you know, the effect of what they've said and how it made you feel.

So I think it's always important, you know, when you are kind of calling them out or calling them in whichever approach is kind of applicable in that situation to tell them how you felt, how did it make you feel, so that they can kind of understand again that whatever they've said, whether it's intentional or unintentional, it's not appropriate. And really they shouldn't do it to anybody else.

Yeah. Okay. Well, I am so sorry, but we are out of time for today. But we're going to have three more sessions, so please join us. Hopefully they'll be on days and times that are convenient for everybody.

I don't know if you'll see these three panel members again, but they can certain be available through the academy to answer any questions, and I will be happy to send the poster to anyone that wants it. I can get the information on attendees or you can email me directly. I will put my email in here really quickly. That's sometimes faster. So thank you very much for spending the hour with us.

We really appreciate it and looking forward to our future conversations.