

# The Classroom, Clinic, and Community: What Can We Do With All Three?

By Mason Trauger, SPT

*Congratulations to Doctor of Physical Therapy graduate student **Mason Trauger** (DeSales University), SPT, winner of the annual CHEP-JHR Student Essay Contest, co-sponsored by the ACAPT Consortium for the Humanities, Ethics, and Professionalism (CHEP) and the Journal of Humanities in Rehabilitation (JHR). This writing competition is designed to encourage deep thinking by students about the role and value of humanities, ethics, and professionalism in academic training and professional life.*

*The sixth in an annual series, the CHEP-JHR Student Essay Contest offers a creative opportunity to ignite critical reflection in Physical Therapy students across the nation, to support holistic approaches to patient care.*

*This year's essay prompt was:*

*"The American Physical Therapy Association (APTA) recently added the core value of inclusion to our profession's Core Values, as efforts have increased to address diversity, equity, and inclusion (DEI) in clinical and educational environments. However, people with disabilities often remain in the margins during DEI-related discussions, and little consideration is given*

*to the importance of the representation of individuals living with disability in our educational programs and professional clinical settings.*

*"Given our professional training and overdue efforts to address DEI across professional settings, what perspectives and/or key strategies could shape our profession to be more inclusive of individuals with disabilities? What can be done, both collectively and individually, to promote a culture of inclusion, belonging, and respect for persons living with disabilities within the field of physical therapy? Why do you believe these efforts will be effective? How will this effort pay off with improved patient care?"*

Vernā Myers is an American activist, inclusion strategist, and executive of her own company providing Diversity, Equity, and Inclusion (DEI) training to corporations, academic institutions, and more. When speaking on these subjects, Myers once said, "Diversity is being asked to the party. Inclusion is being asked to dance." When the American Physical Therapy Association produced the RC 13-20 amendment, acknowledging that individuals with disabilities are an underrepresented minority population in physical therapy education, our invitation to the party was sent. As individual healthcare professionals, we maintain the responsibility

to now ask our patients and community to join us on the dance floor.

Early in my graduate studies, a professor assigned our cohort to participate in a "day in a wheelchair" experience. Student duos traversed a set route across the university campus to complete a checklist of tasks, including a toilet transfer, purchasing food in the cafeteria, and making a grueling journey up a steep hill to return to the classroom. We were asked to document our struggles and reflections after the exercise, which would be reported to the university should any locations benefit from renovations to improve accessibility.

Arms burning, I sat and remembered my father's return home from the hospital in 2015, utilizing a wheelchair himself. A series of medical complications occurred secondary to his acute renal failure, resulting in mild cognitive impairments, muscular atrophy, and permanent visual deficits. While it was a simple task to move our furniture two inches to the left, improving his wheelchair access to his bedroom and bathroom, his visual impairments remained a struggle to surmount.

As my father's cognition improved, we experimented with what could enhance his ability to interact with elements of our home. Additional lights, magnifying glasses, color-coded Tupperware, larger fonts, and white ink on black paper were all methods to accommodate his reduced perceptual capacity. As creative as these efforts were, they would have been pointless without my father's feedback to optimize these strategies to best serve his needs.

Although the "day in a wheelchair" experience provided me with an opportunity to reflect on what it is like to imagine the lived experience of individuals with a disability, it is an insufficient exercise to truly illustrate their daily reality. Rather, it is critical self-reflection, combined with the voices of individuals who have actual lived experience, which expand our capacity to practice with empathy and compassion. Without empowering my father—or any individual with a disability—to advocate for themselves based on their needs and perceptions, clinicians cannot ensure that the best level of care has been provided.

## Crucial Two-Way Communication

This empowerment principle is key in relation to clinical settings. Clinicians should not only provide tailored treatment to each patient, but also aim to empower them and their caregivers through sharing the skills and knowledge necessary for symptom management outside of the clinic. This knowledge distribution, however, is not unidirectional; how can we decide what works best for and in a life that we are not actually living? It is the syncretism of lived patient experiences with the clinician's knowledge of pathophysiology and biomechanics that provides saliency to treatment—not a simulated experience of a day in a wheelchair. Understanding and respecting our patients' values and preferences ensures we prioritize the specific limitations that inhibit each patient's preferred lifestyle. A clinician who adopts a humble stance as both learner and educator can engage in collaborative conversations to optimize patient-care

interactions.

## Addressing Preconceived Beliefs

To approach patient-practitioner interactions with humility, it is crucial to encourage and educate clinicians to reflect upon and acknowledge their preconceived beliefs about disability. It is this introspection that allows us to generate change in concrete practices regarding language and environmental considerations.

### LANGUAGE CONSIDERATIONS

As clinicians, word-choice and phrasing can impact the recipient's perceptions, as evident with considerations for using both *person-first* and *identity-first* language. Person-first language is seen as a step toward humanizing persons with a disability—such as “Mrs. Jones in room 10” versus “the lumbar fusion in room 10.”

Identity-first language shows the importance of an individual's diverse experience; we do not say “they are a person who is religious,” but rather “they are a religious person.” In the same way, an individual may prefer to state, “I am an autistic person” rather than “I am a person with autism.” Just as clinicians should not pre-select interventions for a patient prior to examination, we should not restrict ourselves to one method of speaking, and instead become comfortable adapting to the individual's verbal leads and preferences.

### ENVIRONMENTAL CONSIDERATIONS

In addition to paying attention to the importance of language, implementing specific history inquiries can optimize each patient's experience. Asking “What barriers are you currently facing as a result of disability or impairment?” or stating, “Tell me about the current challenges you face with respect to movement and access,” during the continuum of care should not be seen as an admission of ignorance, but an act of *recognition*. These interviewing components acknowledge that the barriers and limitations one faces extend beyond a diagnosis, and lie within a series of environmental, contextual factors within their daily reality.

In the educational setting, students may not always be able to interview individuals to enhance their understanding of mobility barriers, and resultantly rely on kinesthetic learning to compensate for that lack. They may solely experiment with adaptive equipment and assistive devices to enhance their knowledge of exercise modifications and improve their usage skills for patients with acquired disability or patients transitioning to new equipment. Although well-intended, the translation of this thought process to a “day in a wheelchair”-like simulation is a wholly inadequate experience. A singular day of this activity (which inevitably ends) fails to address the years experienced by others. Medication side effects, the use of bladder/bowel schedules, financial burdens, social stigmas, and a myriad of secondary symptoms from a primary disability cannot be replicated.

## Teamwork: Individual and Organizational

The motto “nothing about us without us” used by disability advocacy organizations highlights the wisdom individuals living with disabilities possess; it is their guidance and experience that ought to guide learning activities that relate to experiences as a disabled person in healthcare education settings. A well-organized disability simulation planned, executed, and debriefed by individuals with disabilities and their caregivers could potentially generate positive benefits. However, an unstructured, poorly-planned activity may intensify biases, fear, and misconceptions about disability.

Perhaps instead, students can observe these individuals within the community to develop better insight and compassion for those who may struggle with the barriers generated by the bias toward a normative, “ideal” body, and gain a greater appreciation of the ingenuity of these individuals to generate alternative methods to succeed in daily activities.

Connecting the experiences of individuals living with disabilities to community-based services is imperative to maximizing functionality. Were it not for my family being provided information regarding the Association for the Blind, my father would only be able to participate in a portion of his daily activities. Other organizations such as Special Olympics, Miracle League, and many others, provide individuals with disabilities additional opportunities for social engagement, interaction, and encouragement of physical activity. Healthcare students performing

service-learning opportunities with organizations such as these can develop critical-thinking skills and improve their understanding of the multiple types of individuals with disabilities and their lived experiences.

An additional method of learning for healthcare students is to treat people of the community in a less formal clinical setting, such as a pro bono clinic, providing no-cost physical therapy services to individuals in need. This semester, my university instituted a year-round, student-run clinic to serve our community. I propose that the synchrony of these community- and clinic-based services can provide a tremendous opportunity to partner with individuals with disabilities. By volunteering in community services, we can provide connections to the 100+ pro bono clinics across the United States to assist individuals in receiving local, cost-effective treatment with better-informed, compassionate care providers. Similarly, we can educate ourselves on these organizations, and serve as a conduit for patients enrolled in these clinics to access assistance from which they may benefit.

## Conclusion: Joining the Dance

Developing compassionate, humble healthcare providers who seek to bolster patient-informed care in both the clinic and community is essential to allow as many individuals as possible to join in the “dance” of inclusion together.

## Resources

1. [The Christopher & Dana Reeve Foundation](#) predominantly serves individuals living with SCI, but has expanded to providing information for caretakers, financial resources, peer mentoring, and support groups for individuals living with paralysis.
2. [Special Olympics](#) is a global organization providing access and community inclusion for individuals with intellectual disabilities through year-round sports training and athletic competition.
3. [Miracle League](#) is an organization oriented towards allowing individuals with physical and mental disabilities to participate in the game of baseball.
4. [The Arc](#) is a national organization dedicated to advocating for enhanced community inclusion and participation for individuals with intellectual and developmental disabilities.

## *About the Author*



**Mason Trauger, SPT** is a second-year Doctor of Physical Therapy student at DeSales University from Allentown, PA. With a history of peer tutoring, mentoring, and a love for evidence-based practice, he aspires to enhance clinical care by emphasizing the use of contextualism within the framework of the biopsychosocial model. Outside of the classroom, Mason plays the saxophone, is a USA Rugby referee, and serves as the club advisor for the DeSales University Men's Rugby Club.