Strategies to Reduce Bias and Racism in Nursing Precepted Clinical Experiences

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ABSTRACT

Background: Nursing programs are tasked with ensuring diverse, equitable, and inclusive (DEI) learning environments for all student learners. With calls to diversify the nursing workforce, engaging nursing preceptors in program-wide DEI initiatives are crucial. Preceptors lacking commitment to DEI could result in poor patient-preceptor communication, tense learning environments, or biased evaluations of students. **Method:** Suggestions for successful strategies to include the preceptor in nursing program's antiracism initiatives are based on the current literature. **Results:** Best practices include providing antiracism training for preceptors, decreasing potential for bias in student evaluations, inquiring about observed racism in clinical sites, and equipping students to be upstanders for antiracism and DEI interventions. **Conclusion:** Dismantling racism and bias in nursing education requires a multilevel strategy. Nursing programs and nurse educators have a responsibility for ensuring a bias-free learning environment and should include the preceptor in antiracism strategic planning. **[*J Nurs Educ*. 2021;60(12):697-702.]**

We are facing a new awareness and a call to action: The coronavirus disease 2019 (COVID-19) pandemic has illuminated significant health and health care disparities, whereas the murders of George Floyd, Breonna Taylor, and other Black people have highlighted the critical need to address social and racial injustices and inequities in all systems, including health care and health care education. Diversifying the nursing workforce is one intervention aimed at reducing health care disparities. Successfully training a diversified student body is critical to achieving this goal and must be intentional; however, finding preceptors for nursing students is a challenge for nursing programs, and ensuring adequate diversity within clinical placements often presents a greater challenge. More than one-third of nursing students at all educational levels are members of racial or ethnic minoritized groups (American Association of Colleges of Nursing [AACN], 2021). Students from groups that are underrepresented or marginalized due to factors such as race, ethnicity, gender, sexual orientation, gender identity, national origin, and use of English as a second language are often paired with preceptors from majority groups who may not be sufficiently prepared to support them. Although some literature exists on preparing preceptors for gender and obesity bias (Hauff et al., 2020; Loeppky et al., 2017; Solomon et al., 1993), little is known about preceptors' preparedness to provide a nonbiased environment in which to precept students who are Black, Indigenous, or People of Color, or to role model antiracist behaviors for students from majority backgrounds. Among the nursing and nursing education organizations that have affirmed their commitment to promoting racial justice and diverse, inclusive environments and policies for students are the AACN (2021), American Nurses Association (2019), National Organization of Nurse Practitioner Faculties (2018), American College of Nurse Midwives (2020), and National League for Nursing (2016); and many colleges and schools of nursing have made a commitment to addressing antiracism by pursuing diversity, equity, and inclusion (DEI) initiatives. It is crucial that preceptor preparation and academic-clinical partnerships be aligned with these institutional DEI goals (Bonifacino et al., 2021).

In nursing education, experiential clinical learning is a cornerstone of the student's experience. Clinical precepted time helps to bridge the gap between formal education and practice. Faculty rely heavily on preceptors to assume a multifunctional role by (1) teaching; (2) counseling, supporting, encouraging, and guiding students as they develop in their nursing roles; (3) role modeling equitable care and appropriate, effective communication with an interprofessional team, and (4) evaluating students' clinical competencies (Girotto et al., 2019; McInnis et al., 2021; Strouse et al., 2018). To optimize their learning experience, students must be matched with strong preceptors who are well equipped to assume these roles, and it is essential that each student's experience be provided in a bias-free environment.

We define preceptors as experienced registered nurses, advanced practice nurses, and clinicians who supervise students and facilitate the application of theory to practice. In preli-

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censure programs, preceptors are registered nurses who work directly with individual nursing students during their final semester. Throughout advanced practice nursing programs, students are paired with preceptors who are practicing advanced practice nurses, physician assistants, or physicians. Advanced practice nursing students may have multiple preceptors during their education. This article uses the term "preceptor" to include any licensed registered nurse, advanced practice nurse provider, or clinician who is assigned to educate a student in the clinical environment.

Preceptors hold a position of significant power and control over students' academic learning and progression. Preceptors who are inexperienced, poorly prepared, or racist/biased can negatively affect student learning by supplying biased evaluations, a strained learning environment, or poor patient-preceptor-student communication. In a race-discordant student and preceptor dyad, an ill-equipped preceptor may harbor implicit bias, causing the student to feel reluctant to engage in learning or isolated in the learning environment (Carney et al., 2000; Wilson-Mitchell & Handa, 2016). Proper preparation, however, allows diverse preceptor-student pairings to result in personal growth, cultural awareness, cultural humility, resolved preconceptions and biases, and improved patient relationships, all of which can contribute to improved patient outcomes. The purpose of this article is to share resources discussed in the literature that can be used by nursing faculty to prepare nurse preceptors for the exacting work of actualizing and role-modeling antiracism in the clinical environment. Although we cannot include an exhaustive list, we have chosen a varied offering of resources to accommodate a wide variety of preceptors, learning styles, and knowledge levels for current and future preceptors.

RESOURCES FOR BIAS AWARENESS IN CLINICAL SETTINGS

There is a lack of published resources on bias awareness in clinical settings; however, a search of the literature reveals some strategies that schools of nursing can use to begin the work of developing preceptors. The equity agenda guideline offered by Effland et al. (2020) is a framework to infuse equity and social justice into nursing education. Their guideline suggests that schools include preceptors in all anti-racism training, require comprehensive initial training for preceptors, and offer continuing education opportunities while infusing DEI concepts into the curriculum and school policies. Effland et al. (2020) have developed a website (http://www.equitymidwifery.org/) that offers scholarly links and information for health professions educators and can be shared with preceptors.

Workshops have been the primary published interventions to reduce bias in preceptors and mentors. For example, in a study by Wilson-Mitchell and Handa (2016), nurse midwifery preceptors, faculty, and students who participated in 1- to 4-hour workshops expressed that they provided a safe environment for self-reflection and growth. The workshops included a lecture followed by case study scenarios completed in small groups. Participants reported that the lecture provided a common language for communication. The scenarios were realistic, included a conflict between a preceptor and student, and were designed to help preceptors and faculty balance client desires with student learning needs. The cases applied principles of social justice such as food insecurity, financial hardship, and stereotypes commonly encountered in the clinical environment. In their published account of the workshop, Wilson-Mitchell and Handa (2016) described five cases that could be adapted by faculty interested in replicating their techniques. The case studies offered the opportunity to critically evaluate the situation presented and discuss possible approaches to balance the interests of the student and patient; however, participants offered the suggestion that an opportunity to role play the scenarios would be beneficial. Participants were provided with online resources for ongoing learning to promote behavioral and attitudinal change; however, there was no follow up evaluation of change.

Workshops focused on reducing bias and improving intercultural mentoring relationships in research programs have also been evaluated. For example, attendees of a 6-hour workshop designed to increase their cultural awareness as research mentors reported an increase in their ability to (1) intentionally create opportunities for mentees to raise issues of race and ethnicity, (2) encourage mentees to reflect on how their research related to their lived experience, (3) move beyond their comfort zone to help mentees feel included in the lab, and (4) respectfully broach the topic of race and ethnicity in their mentoring relationships (Byars-Winston et al., 2018). One interesting feature of the pre-work for this workshop was the creation of a "Culture Box" to stimulate participant reflection on their personal cultural identity. In a follow-up interview conducted 18 to 24 months after the workshop, attendees reported that the most impactful activities had been the culture box, role play activities, and a video depicting what it was like to be the only visual member of a specific group (Womack et al., 2020). Participants felt that the experience increased their openness and cultural awareness and improved their communication with other groups; however, there was no objective measure of behavioral change. Similarly, HIV researchers who attended a 2-day mentoring workshop reported improvement in communicating effectively, aligning expectations, assessing understanding, fostering independence, addressing diversity, and promoting development (Gandhi & Johnson, 2016), although these changes were not evaluated objectively. One strength of this workshop was a small group activity during which participants evaluated and proposed solutions for a current challenge with a mentee.

There were common threads woven through these workshops:

- Key concepts were explored, including race, culture, racism, power, privilege, implicit bias, microaggressions, cultural competence, and cultural humility
- Definition and discussion of concepts enabled participants to develop a common language and understanding of power as well as evaluate beliefs and attitudes toward colleagues and students who were different from themselves
- Experiential learning through case studies, role playing, and consultation about real situations consolidated the knowledge, skills, and attitudes developed through the workshops; however, as a single workshop may not be sufficient for sustained changes in inherent beliefs and

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behaviors, it is imperative that additional reinforcing activities are made available

Workshops have many benefits including acquisition and application of new knowledge. The opportunity to debrief at the conclusion of workshops/training sessions is important and promotes critical reflection, discourse to reconcile tension, and clarification of topics discussed (Gonzalez et al., 2018; Sukhera et al., 2020). It is important to note, however, that although the workshops described previously evaluated participant perceptions of improvement in aspects of precepting or mentoring, none evaluated behavioral change following the workshop. There is limited research examining long-term changes in implicit attitudes or behavior changes after bias workshops (Fitzgerald et al., 2019); therefore, additional strategies are needed to ensure a commitment to culture change and to a focus on bias reduction as a strategy for achieving behavioral change rather than as an end in itself (Fitzgerald et al., 2019).

REDUCING BIAS IN PRECEPTOR EVALUATIONS OF STUDENTS

There is a potential for bias in student evaluations. A study of medical students' written clerkship evaluations revealed that descriptors commonly used for men and non-minoritized students were different than those used for women and minoritized students (Rojek et al., 2019). Evaluations of men included traditionally masculine attributes such as "scientific" and "earnest," and evaluations of women included more traditionally feminine attributes such as "caring" and "poised." Although gender bias in favor of males may be more common in medicine, the opposite may be true in nursing because of the historical patriarchal belief that nursing is a woman-dominant profession (Kiekkas et al., 2016). Studies have found that men in nursing were evaluated more on their physical task performance (e.g., lifting patients) than their nursing knowledge and skills (Powers et al., 2018). Additionally, men in nursing felt that descriptors such as "assertive" were used derogatorily to describe confidence (Kiekkas et al., 2016; Powers et al., 2018). Significantly, bland descriptors such as "pleasant" and "good" were more commonly used in evaluations of minoritized students, and superlatives such as "exemplary" and "motivated" were more commonly used to describe non-minoritized students (Rojek et al., 2019). For medical students, descriptors in evaluations affect course grades and the residency match process. For nursing students, biased descriptors used in letters of reference could negatively affect employment opportunities.

Faculty can provide preceptors with resources to mitigate bias in the evaluation process. The following are some best practices for reducing bias in evaluations by preceptors and faculty:

1. Feedback and evaluations should be conducted while free of distractions and with sufficient time (Quinn, 2020). There is a positive correlation between implicit stereotypes and fatigue, distractions, or time constraints. Faculty can work with students and preceptors to allow sufficient time to complete evaluations.

2. Standards of evaluation should be clearly defined and specific to reduce grading bias. Vague criteria can allow implicit bias to affect evaluations (Quinn, 2020; Sprague, 2016). For instance, a study by Sprague (2016) found that evaluations that use numerical rating scales may result in a lack of variability in ratings (e.g., all threes or all fives) and could reflect factors such as racism, sexism, homophobia, ageism, or other evaluator biases. Although Sprague's (2016) study focused on student evaluations of faculty, bias could similarly affect faculty evaluations of students. Explicit grading categories such as mastery/no mastery may result in less bias than numerical or ordered categories such as proficient, satisfactory, average, or below average. Faculty should revise preceptor evaluations to reflect the specific competencies to be evaluated and consider mastery-based options for grading.

3. Qualitative feedback should consider potential for bias. Some descriptors may introduce bias or reinforce stereotypes, thus negatively affecting student's progression (Quinn, 2020; Rojek et al., 2019). Additionally, some words are microaggressive and prevent feedback acceptance and subsequent learning and growth. Constructive feedback should include information that is useful for the student's professional growth and improvement, specifically address areas of excellence as well as areas in which improvement is needed, and avoid the following:

- Making inferences: Feedback should describe observations of behavior the preceptor or faculty member have witnessed rather than interpreting that behavior (Dolan & Gates, 2021; Rojek et al., 2019). It is important to recognize that there may be a legitimate reason of which the preceptor or faculty member is unaware for student behavior normally deemed unacceptable. For example, a student seen looking up an evidence-based response to a preceptor's question on their cell phone could be perceived as being inattentive or disinterested
- Lacking specificity: Observations should include positive behavior with specific details (Dolan & Gates, 2021; Rojek et al., 2019). For example, rather than describing a student as "conscientious," a preceptor might document that the student called a clinical patient to follow up on the patient's questions or worked with their preceptor to address discrepancies in a medication list
- Being personal: Evaluators should avoid referring to personal attributes because their cause is often based on conjecture, and some have been commonly used to classify minoritized students. For example, "pleasant" is more commonly used to describe underrepresented students, and "well-spoken" often indicates that the evaluator is surprised by a Black student's linguistic abilities (Rojek et al., 2019). Such attributes do not describe the student's competence, thus avoiding them altogether could reduce the potential for bias
- Evaluators should be aware that superlatives such as "exceptional," "outstanding," and "best" are less commonly used in narrative evaluations of underrepresented students (Rojek et al., 2019). As these words are perceived as more positive than "good," "well," or "adequate," preceptors should be aware of the inequitable use of terms and avoid using them. Discussing specific actions or competencies that the evaluator deems exceptional, good, or adequate provides a more objective description of the student's performance and decreases the risk of bi-

ased interpretation. The referenced studies relate to medical students; there is limited evidence available related to nursing education, although the implications remain the same

Nursing faculty can develop training or preceptor manuals that include information on how to provide non-biased feedback for nursing students. Northwestern University's Feinberg School of Medicine offers an open-source website (https://www.feinberg.northwestern.edu/md-education/learning-environment/index.html; Northwestern Medicine, 2021) that houses their efforts to become an anti-racist, inclusive institution. Two resources on their site may be of benefit to faculty and preceptors who are developing preceptor resource manuals. The first is a 30-minute continuing education module titled Addressing Bias in Learner Assessment (Dolan & Gates, 2021). This module is a tool to identify and reduce bias in assessment and is linked to evaluations that the preceptors complete. The second is a brief module on avoiding bias in a letter of recommendation and includes words to avoid when describing students (Northwestern Medicine, 2021a).

EVALUATING CLINICAL SITES FOR BIAS

It is important that students evaluate clinical sites and preceptors for bias. As part of the equity agenda guideline developed in their work with midwifery programs, Effland et al. (2020) recommended including two questions that could be used in the evaluation of the clinical preceptor and site: "Did the instructor [or preceptor] create and maintain a learning environment free of racism?" and "Did the student observe or experience racism in any interactions with faculty, [preceptors, or patients]?" It is important to add similar questions to the preceptor's evaluation of the student to determine whether the student exhibited any evidence of racism. Although it is not ideal for faculty to learn about issues in the clinical environment at the end of the semester, it must be acknowledged that students may hesitate to disclose issues due to fear of retribution or losing a clinical site. Additionally, faculty should review and reflect on these important student evaluations as part of an ongoing assessment of the appropriateness of the clinical setting. Faculty and nursing programs must create a culture and environment in which students feel that they can share their concerns safely.

BARRIERS

Nurses have a professional responsibility to provide and role model unbiased, antiracist care, and nursing faculty are responsible for ensuring that students receive their clinical education in unbiased, antiracist environments; however, there are potential barriers to requiring antiracism or implicit bias training for preceptors. Preceptors are often unpaid volunteers and may not be considered employees of an academic institution; therefore, if the clinical organization does not mandate the training, the clinical preceptor may not feel obligated to comply. Additionally, faculty may fear losing clinical sites and/or preceptors by making this request. Moreover, despite a national push for DEI initiatives as well as the promotion of anti-bias and antiracism goals and values within health care organizations, the specific strategies of an individual academic institution may not align with those of a clinical organization. In advanced practice programs, the fact that preceptors may be other advanced practice providers (e.g., physician assistants) or physicians can also present a barrier. Education in other disciplines may not provide insight in to nursing education (Chen et al., 2016). To encourage buy-in, nursing programs may consider offering incentives to clinical preceptors, such as continuing education credits, annual sponsored preceptor conferences, or access to educational resources. Some incentives that have been requested by preceptors include preceptor training, adjunct faculty status, opportunities to take university courses, opportunities to guest lecture, and financial compensation (Roberts et al., 2017). Monetary compensation has been discussed as a strategy for recruiting and retaining preceptors (McInnis et al., 2021). Programs that pay preceptors should have a solid foundation to mandate antiracism and anti-bias competencies. Faculty and nursing programs may consider joint development and planning of DEI efforts via academic-practice partnerships in the form of dedicated education units (DEUs). There is a vast amount of research on DEUs in undergraduate nursing (Dimino et al., 2020; Rusch et al., 2018), and emerging evidence on the usefulness of this model in advanced practice nursing is available (Hall et al., 2019). Dismantling systems of racism is admittedly a tall task and will require bold and solidly designed strategies. Further research is needed to design best practices for ensuring preceptor buy-in to mandatory trainings.

Assigning the responsibility for maintaining preceptor records of compliance is an added task for nursing programs. Clinical placement offices can use staff who are already in place to maintain this information.

IMPLICATIONS FOR NURSING EDUCATION AND RESEARCH

Nursing education's goal of providing an antiracist and bias-free clinical learning environment for students can be achieved only by engaging clinical preceptors; therefore, strategic planning should consider including preceptors (Effland et al., 2020). Intentional strategies may include mandating in-depth in-person training, virtual learning, or self-paced modules for preceptors to complete prior to precepting students or requesting proof of prior completed training. Active learning strategies such as role play and standardized or virtual patient simulation can build on didactic concepts and offer preceptors an opportunity to practice antiracist skills that may lead to behavior change (Sukhera et al., 2020). There are multiple strategies and resources for faculty to consider. Although we do not recommend any particular resource, we do recommend that in-person, in-depth trainings precede opportunities for virtual learning or self-paced modules to allow for facilitated learning, group debriefing, and reflection. Self-paced modules and virtual learning are great tools for validating yearly competencies. There is a need for a national evaluation of various training and delivery methods to evaluate best practices.

Nursing programs should also implement policies and procedures that promote institutional accountability for DEI.

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When assigning students to clinical placements, nursing faculty should intentionally consider their immersion in settings with diverse patient populations. All students may benefit from being precepted in clinical sites that treat patients from predominately diverse backgrounds, or by being precepted by a provider whose experiences are different from their own. Such experiences have the potential to reinforce structural and social drivers of health didactic content and are recommended for mitigating bias. There is a need to develop educational policies that center on the clinical learning environment. Students should have a method of reporting racism, bias, and microaggressions without fear of reprisal. Nursing programs can consider developing policies or processes for discontinuing use of clinical sites that consistently lack respect for DEI, or of preceptors who exhibit racism and bias. Additionally, the clinical learning environment and preceptor should not accept biased or racist behavior by nursing students. Programs should maintain communication with clinical preceptors to receive feedback on student behavior in the clinical environment related to antiracism and bias. Nursing faculty should also ensure that their curriculum and pre-clinical training includes anti-racism concepts specific to the clinical environment. Research on best practices for addressing biased and/or racist student behavior in the clinical environment is needed.

There is a need at the programmatic level to prepare students to handle patient bias against the clinical provider/student. Although little has been published on this topic in nursing literature, studies have suggested that adequate interventions such as upstander training, specific policies for reporting, and a method for debriefing encounters in which students experience patient bias are necessary (Chandrashekar et al., 2020; Paul-Emile et al., 2020). Upstanders act against racist, microaggressive, or other negative behaviors, increasing the likelihood that the offender will stop the behavior (bystanders, in comparison, observe or become indirect victims of offensive behavior) (Clark, 2020). Becoming an active upstander to address racist or biased behavior in the clinical environment is important but can present challenges for which students must be professionally prepared.

Nursing programs should pay careful attention to the clinical evaluation process for students. Clinical preceptors are generally required to evaluate students. Specific training on reducing bias in assessment is necessary for everyone engaged in the evaluation of student learning. Nursing programs can review (1) their evaluation forms to ensure that preceptors are provided with objective prompts with which to evaluate students, and (2) disaggregating preceptor evaluations of students by race; if patterns emerge, they may indicate opportunities for further training or a need to reassess the use of a site/preceptor. Lastly, nursing programs are developing excellent tools, training methods, and policies around anti-racism and bias awareness, yet the literature remains limited. Dissemination of related best practices initiatives are needed.

Further research is also needed on best practices to create clinical environments that are safe and unbiased for diverse students, patients, and preceptors. Because preceptors are an integral component of nursing education, future studies could develop and evaluate preceptor training programs to prepare graduating nursing students to assume this role with a focus on acquiring, implementing, and sustaining anti-racism and antibias behaviors. Nursing faculty may consider a didactic module and intra-professional simulation activity that pairs graduating students with first-semester students and incorporates upstander training to offer future preceptors a language for addressing bias and/or racism in the clinical environment. In addition, institutions should evaluate the effectiveness of changes in policies and procedures that concern preceptor supply and satisfaction, and student satisfaction and attainment of competencies.

CONCLUSION

The era and aftermath of COVID-19 has sparked a global call for racial reckoning, and it is imperative that it be answered with an intentional effort to create sustainable policies and programs that dismantle racism and bias in nursing education. The call to diversify the nursing workforce dictates that it be made safe from racism, bias, discrimination, and microaggressive behaviors. Clinical preceptors and environments that are supportive and respectful are essential to students' success as learners and future health care providers. Nursing programs have an obligation to (1) include clinical preceptors in planning strategies to address racism and bias, (2) establish policies that reinforce their commitment to DEI efforts and antiracism, and (3) become champions of diversity by creating learning and working environments characterized by safety, dignity, and respect.

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