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Family Medicine Clerkship Preceptors' Experiences Welcoming and Supporting Medical Students of Color

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Abstract

Purpose: Medical students of color (MSoC) regularly experience discrimination and mistreatment during medical school. Preceptors have the potential to provide meaningful support for MSoC while on their family medicine clerkship rotation. This mixed-method study explores family medicine clerkship preceptors' challenges, current practices, and institutional needs related to welcoming and supporting MSoC.

Methods: Any lead preceptor at a University of Washington-affiliated family medicine clerkship teaching site was eligible for this study. From June to September 2022, seven focus groups were conducted with a total of 32 participants. Study team members coded transcripts for key themes related to participants' experiences of working with MSoC. All participants were asked to complete a short survey, which included both demographic questions and questions regarding their beliefs and abilities to welcome and support MSoC.

Results: Many preceptors felt underprepared and unsure about when and how to support MSoC. Current strategies employed by participants included adding a semi-scripted orientation conversation to discuss how they will be supported during the rotation and who they can talk to if they encounter any discrimination and/or microaggressions. Participants also suggested that the medical school should offer additional trainings for preceptors, such as mitigating microaggressions toward students.

Conclusions: Lead preceptors are well positioned to empower and support the students they teach. This exploratory, single-institution study offers some insights into the challenges, current practices, and suggestions for institutions to support MSoC during clinical rotations. We recommend additional research to help validate our findings.

The University of Washington Human Subjects Division has determined this study qualifies as exempt. IRB ID: STUDY00015212

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INTRODUCTION

Diversifying the physician workforce is not only a necessary step toward creating a more just and equitable health care system; it has also been linked to better health outcomes for patients.[1,2] However, medical students of color (MSoC) continue to disproportionately experience mistreatment throughout medical school training.[3-6] A recent study found 60% of MSoC experience microaggressions on a weekly basis.[7] Microaggressions and other forms of discrimination can have a lasting impact on students including increased burnout, reduced self-confidence, and depression.[4,7,8]

There have been recent calls from medical educators for clinical preceptors to improve the learning environment for MSoC.[6,9-12] A recent focus group study of Underrepresented in Medicine (URM)

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medical students elucidated some of the ways students would like to be supported by their clinical preceptor in the wake of a microaggression. These strategies included: preceptors debriefing with students after a racist incident has occurred and developing an appropriate response based on student preferences.[10] However, Acosta and Ackerman-Barger point out that engaging in conversations about race and racism with learners can be overwhelming and stressful for untrained faculty. They assert that preceptors need to first undergo intense and introspective faculty development training that covers topics such as race, power, identity, and social justice to be prepared to support MSoC.[9]

The University of Washington School of Medicine (UWSOM) is a de-centralized school with six regional campuses across Washington, Wyoming, Alaska, Montana and Idaho (WWAMI).[13-15] Students complete their family medicine third-year required clerkship with either a six-week rotation or a longitudinal integrated clerkship (LIC) at one of 79 teaching sites across the WWAMI region. Each clerkship teaching site has "clerkship leads," usually one or two family medicine physicians who are primarily responsible for both teaching and evaluating students. In this model, students learn clinical medicine in locations where they are often new to both the clinic and the community. Further, students are also frequently the only trainee at a particular teaching site.[14,15] This unfamiliar environment often leaves students feeling isolated and disconnected. For MSoC, these feelings may be intensified by the cultural and racial isolation they experience in these new communities.[6,16,17] Navigating this uncertainty leaves MSoC in need of additional support and guidance from their clinical preceptors.

The UWSOM does not currently mandate any trainings for preceptors specifically related to supporting MSoC. However, in the last three years, lead family medicine preceptors have had the opportunity to attend in-person sessions sponsored by the Family Medicine Clerkship Program that include "Racism in Medicine," "Standing Up and Showing Up for LGBTQ Learners and Patients," and "Reporting Learning Environment Concerns." UW Medical Students are trained how to report microaggressions and other acts of racism through the UWSOM Learning Environment Reporting Tool. Students are also expected to complete "Medicine Health and Society" I and II courses that explore themes of diversity, inclusion, and equity.

To our knowledge, there has yet to be a study that solicits the perspectives of teaching physicians to understand their experiences supporting MSoC. Through a mixed-methods approach, our research team explored their specific challenges, current practices, and identified training needs for preceptors to better support MSoC in the future.

METHODS

Setting, Participants, and Recruitment: Between June and September of 2022, our research team conducted seven focus groups. The focus groups ranged between 35 minutes to one hour in length. The size of the focus groups ranged from three to six participants. Eligible participants included any Family Medicine physician who is currently a primary teacher and evaluator at a UW School of Medicine Family Medicine Required Clerkship teaching site. At the time of this study, there were 41 six-week family medicine clerkship sites and 38 LIC teaching sites. Out of the seven focus groups conducted, five took place at a faculty development meeting for family medicine clerkship site leads in Seattle, Washington. Our research team sent an email invitation to two additional LIC teaching sites, both of which agreed to participate. These focus groups were conducted at the teaching site. Each focus group was facilitated by a member of our research team. Every session was audio recorded and transcribed. Participation was voluntary.

Before each focus group commenced, participants were asked to complete a short survey collecting demographic information, teaching experience, and their perceived effectiveness in supporting MSoC on a Likert Scale of 1-5.

Analysis: Four members of the research team conducted a directed content analysis by independently reading and coding all transcripts.[18] After each focus group was independently coded, coders then met to identify key themes, refine codes, and create a single coding scheme.

The University of Washington's Human Subjects Division reviewed and approved this study.

RESULTS

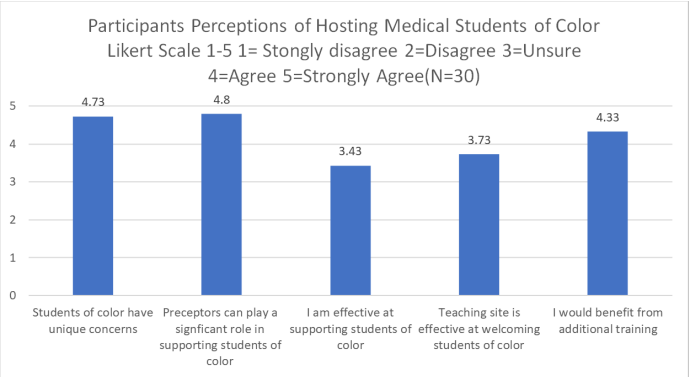
A total of 32 preceptor leads representing 18 out of 79 family medicine clerkship teaching sites participated in the study. Table 1 describes participants' age, gender, self-identified race and ethnicity, practice setting, practice state, teaching experience, practice type, and medical specialty. Among participants, the majority were White (83.3%) and 63.3% were women. All participants had at least one year of teaching experience and 76.7% had five or more years of experience. The majority of participants practiced in Washington State (73.3%) and 15.6% in Seattle, Washington. Participants from rural teaching sites with a Rural-Urban Commuting Area Code (RUCA) of 7 or higher represented 43.3% of the focus group.[19]

Table 1 Self-reported Participant Demographic Information (N = 30*)

	Number of Participants	%
Age (Years)		
20-30	1	3.3%
31-40	10	33.3%
41-50	9	30.0%
51+	10	33.3%
Gender		
Male	11	36.7%
Female	19	63.3%
Self-Reported Race		
White	25	83.3%
Black	2	6.7%
Two or more Races**	2	6.7%
Unknown	1	3.3%
Ethnicity		
Hispanic or Latino	2	6.7%
Jewish	3	10.0%
Practice Setting		
Rural***	13	43.3%
Suburban/Urban	17	56.7%
Practice State		
Washington	22	73.3%
Wyoming	1	3.3%
Alaska	2	6.7%
Montana	3	10%
Idaho	2	6.7%
Years of Experience Teaching		
1-4	7	23.3%
5-10	9	30.0%
11-15	5	16.7%
16 or more	9	30.0%
Practice Type		
Residency Site	17	56.7%
Non-residency Site	13	43.3%
Medical Specialty		
Family Medicine	30	100.0%

*Two focus group participants did not complete the survey
** Includes: Indigenous and Northern European; Caucasian and Native American
***Rural is defined by Rural Urban Commuter Area Codes 7 or higher: 7= Small town core: Primary flow within an urban cluster of 2,500 to 9,999 in population.

Figure 1 reports participant responses to Likert Scale questions in the survey related to perceptions and abilities to support MSoC. All but one participant (96.7%), agreed or strongly agreed that MSoC have unique concerns with respect to the clinical learning environment and all participants agreed or strongly agreed clinical preceptors could potentially play a significant role in supporting MSoC. However, when participants were asked if they felt they were effective at supporting MSoC, only 23.3% agreed or strongly agreed. Further, 96.7% agreed or strongly agreed they would benefit from additional training in mentoring and supporting MSoC. Our analysis found no statistically significant difference between responses from participants practicing in rural versus urban teaching sites.



The seven focus groups yielded four major themes: (1) Challenges to preceptors themselves or MSoC, (2) Current practices for ensuring MSoC feel welcomed, (3) Current practices for supporting MSoC following a microaggression, and (4) Medical school strategies to help preceptors' efforts to better support MSoC.

Challenges to preceptors or students

The most common challenge preceptors described was hesitance around when and how to address instances of microaggressions. Participants described feeling unsure of what language to use, concerns about "othering" MSoC by highlighting potentially racist incidents, and uncertainty about their role in addressing these issues with students.

"I just would want to make sure that we're not like taking it too far and kind of over identifying people of color and treating them different in some way in the orientations that we're given. And I'm not sure where that balance lies..."

"...I'm pretty sure I could have done better, I'm sure I could have done worse, but it kind of raised to the level of I need to get better at this."

Many preceptors also described situations where they struggled to balance patient care with addressing microaggressions; their examples included instances of patients making inappropriate comments about or in front of students.

"[After the microaggression] it was a difficult moment of how to address it. And because of the patient's age, we elected to not address it specifically in the room, but to make it into a learning experience afterwards. And that's actually what our teaching moment was for the team later that day... not everybody agreed with that as the right outcome. But when you have a sick, a very sick 99 year old patient in the hospital, in my humble opinion, it's not always the right thing to do, to call that patient out in front of a number of people, for making a microaggression."

Finally, many preceptors expressed concerns about reporting processes; they felt that microaggressions are likely underreported, and that hierarchies and power dynamics may limit student reporting.

"I'm sure it's much underreported. But rarely do I hear from one of the UW students that they had an issue."

"...obviously there's a power dynamic, number one, and then number two, it's someone who will, you're presuming, based on their appearance hasn't had those same experiences of micro aggressions...because they are someone who appears white or whatever. So kind of, maybe not being comfortable having those conversations or kind of presuming that that person won't understand or not be able to do something about it, or I'm not sure."

Current practices and suggestions for ensuring students feel welcomed

To ensure MSoC felt welcomed and supported at their sites, preceptors suggested several practices, including explicitly discussing procedures for reporting instances of racism or microaggressions, and adding a specific scripted conversation about bias to all new student orientations. Because preceptors recognized that MSoC have a unique experience in medicine, many emphasized the importance of forming open and trusting relationships early in the rotation to encourage disclosure.

"I ask them to call me by my first name, I give them my cell phone number, we talked about the fact that they are now doctors in training, so they should consider their preceptors, essentially, their peers. And that, you know, they don't need to think about a class distinction system. And also, that, you know, I'm safe, as well as our preceptors. We're all safe to talk about stuff like this. So I've never gotten raised eyebrows or gotten look cold feeling in response to that."

"I have kind of developed a habit that I think has worked well of spending upfront a little more time with students

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to kind of orient them to the clerkship, but also to get to know them and go through like some questions that are more just getting to know them as a whole person."

Current practices for supporting MSOC following a microaggression

Though many preceptors shared concerns about when and how to address microaggressions, others shared examples of what worked well for them. Preceptors identified key strategies such as finding a safe and private space to discuss the incident, and others talked about using the microaggression itself as a learning moment to have a larger conversation about bias and discrimination with students and faculty. Preceptors across focus groups identified the need to individualize the response to microaggressions based on the situation and the students; this finding reinforced the importance of establishing trusting relationships with students to best support them.

"I let them know that they have a completely safe space with me to talk about aggressions or microaggressions."

"I see it really as an opportunity. Because again, I think most people are well intended and are unaware that they are having a microaggression. And I think there's an elegant way to raise their awareness about it without being mean or degrading. And have everyone in the room feel okay about that interchange and feel elevated... I feel like it's something I should have in my back pocket for when the opportunity presents itself."

"...I've asked for feedback and guidance as to how they would prefer that we address those situations."

Medical school strategies to help preceptors' efforts to better support students of color

Preceptors clearly care deeply about their students' experiences and want more tools to support them. In focus groups, they distinctly expressed their need for more training and resources. Specifically, many discussed their desire to have a consulting service and/or training on how to discuss and mitigate microaggressions; this finding echoed their concerns about the language used to discuss microaggressions. They also requested tools such as scripts or checklists they could use when welcoming students to the clinical site or when processing microaggressions.

Many preceptors also expressed interest in receiving more feedback from MSoC themselves as a strategy to better understand their experiences and improve their responses.

"When I'm in the moment, I would like a service that I could call to debrief a case, as it happens after the fact, like, you know, like, just like you call poison control, and they say, Okay, do this, this, this, and this, you know, I'm not going to remember how to deal with all the different toxic elements out there. But it would be nice to have like an advisory committee that you could call and say, "This is what happened." And how would I handle it next time..."

DISCUSSION

This study has several strengths that contributed to the validity of our findings. Focus group conversations were able to offer details and context of participant experiences that would not otherwise be captured in more quantitative methods. Our facilitators encouraged an open and honest conversation among participants on sensitive topics, such as racism in medicine. Further, the survey questions allowed our research team to capture preceptors' perceptions of teaching MSoC before they began discussing such topics in the focus group setting. However, this is a single institutional study that did not attempt to randomize the sample of participants or measure change over time. Most of the participants were in Washington State (73.3%) and 15.7% lived in Seattle. Therefore, the results may reflect a regional perspective that may not be generalizable to other areas of the country. In addition, the participants in this study were predominately White (83.3%). Our research team did not attempt to capture the differences among different racial or ethnic groups, nor did we explore the intersectionality of other identities such as gender or sexuality.

It is also important to note that all the participants were family medicine clerkship site leaders.

It is possible family medicine preceptors who are not site leads may have perspectives on supporting MSoC that are not represented in this study. It is also possible preceptors from other medical specialties may also have different experiences and opinions on this topic. Future research should expand on our study to include a larger and more diverse sample of

preceptors across multiple specialties and institutions.

Our research also did not systematically capture what training, if any, the participants completed related to supporting MSoC prior to the focus group conversations. A more complete understanding of participants' past trainings would have better contextualized their requests for additional training and the topic areas requested in this study.

Both the survey and the focus groups underscored the disparity between preceptors' interest in and their ability to support MSoC. In the survey, all participants agreed or strongly agreed they could play a role in supporting MSOC. However, only 57% of participants agreed or strongly agreed they are effective at supporting MSoC. This disparity was also elucidated in the focus group conversations. Many participants were motivated to support MSoC, but expressed anxiety and reluctance about having race-based conversations with students.

The focus group participants offered several strategies to both ally with the student during microaggressions and help students feel welcomed at their clinical training sites. Some strategies mentioned by participants such as finding a safe and private place to discuss the incident with the student and individualizing the response, were also echoed in the published literature.[20-23] More research needs to be done to better understand the effectiveness of these practices.

Participants also expressed a need for additional training to support MSoC. Our research revealed general topics, such as mitigating microaggressions, but more research needs to be done to better understand specific content needed and how to best disseminate this content to busy preceptors. It is also important to note that stand-alone trainings on microaggressions are only a partial strategy for addressing larger issues of racism in medicine. Many microaggressions are rooted in stereotypes and generalizations, so broader discussion of the racist roots of those microaggressions may encourage preceptors to think more broadly about racism in medicine. For example, it is important to understand that the longstanding racist stereotype of Black people having lower intelligence contributes to both the lower numbers of Black medical students and the culture of microaggressions challenging their intelligence.[24] In addition, these trainings are rarely required and even more rarely come with any accountability mechanisms, so faculty face no consequences if they continue to make offensive statements. Any trainings offered to preceptors should include larger discussions of systemic racism in medicine and should include clear policy or procedural changes that specifically encourage behavior change.

CONCLUSIONS:

The clinical years of medical school education pose a significant amount of stress to learners, especially MSoC who must navigate both the academic rigors and systemic racism. Preceptors of MSoC have a unique opportunity to empower and support the students they teach. This exploratory, single-institution study offers some insights into the challenges, current practices, and suggestions for institutions to support MSoC during clinical rotations. We recommend additional research to help validate our study findings.

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