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Navigating Communication in Racially Concordant Care: Considerations for Medical Education

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ABSTRACT

Background and Objectives: Black/African American medical professionals and students engage in patient-centered communication in ways that are not yet described in medical education literature. The purpose of this paper is to explore the ways in which Black/African American attending physicians, residents, and medical students enact patient-centered communication while interacting with their Black/African American patients.

Methods: Forty-one Black/African American attending physicians, residents, and medical students were recruited through a snowball sample of the authors' personal and professional networks. Participants engaged in semistructured interviews about their experiences of being Black in a predominantly White profession. Data were transcribed and analyzed using thematic analysis.

Results: Black/African American attending physicians, residents, and medical students used patient-centered communication when engaging with Black/African American patients. Rather than relying on physician-focused styles of communication, participants situated their communication within their shared cultural backgrounds and approached their patients as they would approach family members. Participants reported that by centering the patient, they could communicate in a way that reflects shared norms and understandings.

Conclusions: This study suggests that Black/African American attending physicians, residents, and medical students approach communication from a personal and familial space in an effort to disrupt conventional modes of provider-patient communication that do not center the patient or consider the patient's cultural background.

INTRODUCTION

Effective patient communication is essential for positive patient outcomes.[1,2] Unfortunately, communication training is often brief, not reinforced throughout the curriculum, and not properly assessed.[1,3] This lack of consistent training and assessment, combined with increasing competing demands on time, can lead to poor physician communication skills.

Communication skills have been studied myriad ways over the years. More than 3 decades ago, Emanual and Emanual described four models of the physician-patient relationship.[4] These models included the paternalistic model, informative model, interpretive model, and deliberative model. Still today, physicians may engage in aspects of these communication models. For instance, a physician who uses a paternalistic communication style may speak over their patient or make decisions on their behalf without engaging in shared decision-making. Physicians ascribing to the more deliberative communication style may choose to focus only on the health-related aspects of consultation rather than seeing the patient more holistically. This early research on physician-patient communication led to the Institute of Medicine declaring that medical care should be patient-centered.[5] Epstein and Street defined patient-centered communication as four processes and outcomes of the patient-provider interaction.[6] These included eliciting, understanding, and validating the patient's perspective; understanding the patient within their own psychological and social contexts; reaching shared understandings of problems and treatments; and sharing power with patients by offering decision-making and meaningful engagement in treatment choices.[6]

Patient-centered communication is especially important when interacting with populations that are marginalized

because of their race, gender, sexuality, socioeconomic status, and/or other demographic factors.[7] Previous work with Black/African American attending physicians, residents, and medical students[8] found that these individuals engaged in patient-centered communication. However, much of this communication was due to shared experiences and the provider's understanding of culture rather than the result of communication training. This research also found that Black/African American attending physicians, residents, and medical students engage in patient-centered communication in ways not yet described in the medical education literature.[8] Thus, the purpose of this paper is to explore how patient-centered communication informs the ways in which Black/African American attending physicians, residents, and medical students engage with patients.

METHODS

Participant Recruitment

Participants were 41 Black/African American medical professionals and students, including 17 Black/African American attending physicians, 10 residents, and 14 students from two medical colleges in the Southeastern United States. We used the terms "Black" and "African American" interchangeably to reflect students' self-referencing practice. Participants were recruited using the snowball method originating from a combination of researchers' personal/professional networks. Initial recruitment included personal emails and presentations in various clinical and classroom settings. This study was approved by the university's institutional review board.

Data Collection

We conducted semistructured interviews with each participant, exploring moments when they perceived their race/ethnicity as salient in their profession. Sample questions included "Describe a moment in your educational or clinical training when you perceived your race/ethnicity to be important" and "How can medical education/the medical profession better support African American physicians?" We used probing to assess participants' reactions to these moments and how they intersected with their professional identity, which we defined as thinking, feeling, and acting like a physician.[9] Interviews lasted between 45 and 60 minutes and were audio recorded and transcribed for accuracy. The interview protocol can be found in Table 1.

Data Analysis

As part of a larger study, interviews underwent two levels of coding. First, we coded interviews using the conceptual framework developed out of Black feminist scholarship[10]—a framework that recognizes the interlocking nature of oppression among minoritized groups and the need for research paradigms that are developed out of these experiences. This framework helped elucidate the causes, consequences, and conditions[11] for when, why, and how participants' race/ethnicity was experienced as prominent. The team then took their interpretation back to participants for member checking. Participants who engaged in member checking (six students, two residents, and four attending physicians) completed a second phone interview in which the team's interpretation of the data was presented and participants commented on the ways in which the interpretation fit their experiences. We made adjustments to the findings based on participant responses.

We completed a second level of coding once we better understood the experiences of Black/African American medical professionals in a traditionally White profession. This second level of coding isolated moments when participants talked about patient communication. We analyzed these data using thematic analysis[12] to better understand participants' experiences with patient-provider communication. The research team engaged in ongoing discussions to interpret our findings. Throughout the analytical process, we used our own experiences as race scholars in medical education (T.W., N.W.), with Black/African American physicians (T.T., D.W.), and in communication studies (L.A.) to interpret the data.

RESULTS

Black/African American attending physicians, residents, and medical students interviewed for this study approached communication from a personal and familial space in an effort to disrupt conventional modes of communication that do not consider patients' unique backgrounds. By engaging in this type of patient-centered communication, participants connected with patients in ways that facilitated the clinical encounter. Table 2 highlights the findings of this study.

Communication as Sensemaking

Participants approached patients using familial and personal communication, and descriptive language that is not often seen in medical communication research. For example, these providers described their patients as family members, or as someone with whom they have a close relationship, rather than as a client, patient, or someone coming in for a service. One resident stated, "My patients [and] their caregivers remind me of my aunties and uncles or my grandmother. So, I try to think, What would my grandmother be able to understand about this conversation?" Others described how thinking about their patient as a family member helped facilitate patient interactions. One resident said, "You feel like this [patient] could be my cousin [and] I am able to let my guard down a little bit. The way I get the history from those patients is just like a casual conversation." These quotes demonstrate that practitioners and trainees use communication to improve their diagnostic ability and their patients' ability to understand the encounter, suggesting that sensemaking is a step of the diagnostic process.[13] The providers and students in this study indicated that their personal experience is as relevant to the sensemaking process as their professional expertise.

Several participants also indicated that another motivation for engaging in patient-centered communication was building trust in the Black community. Many participants noted that building trust in the Black community can make medicine more accessible to Black patients. They linked their work back

TABLE 1. Interview Protocol for Semistructured Interviews With Attending Physicians, Residents, and Medical Students

Interview questions
1. In terms of who you are, tell me a little bit about yourself. Where did you grow up? What was the racial composition like around you? How would you describe the social class of those around you? What did your parents do? Discuss any salient characteristics in your upbringing that have influenced you as a physician.
2. How salient is your racial/ethnic identity? In what ways does your race/ethnicity influence your experiences in medicine?
3. Describe a moment in your educational or clinical training when you perceived your race/ethnicity to be important. How have these experiences affected you?
4. What experiences have you had either in the classroom, clinic, or extracurricularly that influenced your professional identity?
5. In what ways does your race/ethnicity play a role in how you think of yourself as a physician?
6. What kind of doctor are you because of your experiences/upbringing?
7. Do you think you would practice differently if you weren't a minority?
8. For other African Americans entering the medical profession, what advice would you/do you give them?
9. How can medical education/the medical profession better support African American physicians?

TABLE 2. Participant Quotes by Participant Type

Participant Type	Quote
Resident	My patients [and] their caregivers remind me of my aunties and uncles or my grandmother. So, I try to think, What would my grandmother be able to understand about this conversation?
Resident	You feel like this [patient] could be my cousin [and] I am able to let my guard down a little bit. The way I get the history from those patients is just like a casual conversation.
Physician	Part of this implicit contract we have [with Black patients] was that you needed a thing that you couldn't do for yourself. You were vulnerable, and [now] we can do something about it.
Physician	I think one of the things that is extremely helpful in these situations, that helps to mitigate these factors, is having physicians of color who are able to give good dialogue with their patients regarding [their disease].
Student	Black patients are significantly less likely to have consistent follow-ups with neurologists than other races, and part of that reason, I imagine, is the ways we again explain certain things to people have to connect with them, and I feel like [I have] that kind of cultural competency. If your patients don't understand what you're saying, then you aren't treating them.
Resident	I've been through a lot of what my patients have been through. Because I was a minority in the lower socioeconomic status, [they] don't have to explain any of that to me. I get it.
Student	I just kind of speak clearly, plainly; I just feel the air is just a little bit clearer.
Physician	Some of them [White professors] didn't really understand the [Black] culture. They never understood and they never took the time to understand why this patient would do the things they did.
Student	As a physician, I'll be able to not only understand my community, but make sure I can understand everybody else's community, because I know what it's like to be misunderstood, and I know the implications of that.
Physician	Being able to talk Spanish to Hispanic patients and share common cultural elements I think is helpful in as much as identifying barriers to care.
Physician	From a racial perspective, [my] mother was White, father Black, so that provided some additional perspectives that I use to create common ground with patients.
Resident	Things are different in Black families and Jamaican and African families, and I can relate to a lot of different groups of people just based on the person that I am and where I come from and how I was raised.

to medicine's history of structural racism and discrimination against Black individuals. As one attending physician stated, "Part of this implicit contract we have [with Black patients] was that you needed a thing that you couldn't do for yourself. You were vulnerable, and [now] we can do something about it."

Communication as Culture

Participants described connecting with their patients in a way that recognizes shared experiences and a shared culture. A resident described using his own experiences to better understand and approach his patients, saying, "I've been through a lot of what my patients have been through. Because I was a minority in the lower socioeconomic status, [they] don't have to explain any of that to me. I get it." Demographic background is often related to culture, a factor that heavily influences a patient's experience with the health care system and health care interactions.

The importance of cultural competency has been recognized during the past decade.[14] Cultural competency refers to an understanding of the ways in which cultural factors influence patient behaviors, attitudes, and beliefs about health and health care.[15] Providers who practice culturally competent communication engage with patients in a way that considers the patients' cultural background before, during, and after a patient encounter. This might be as simple as making eye contact with someone experiencing hearing loss or as complex as recognizing various cultural preferences for having family members present and involved in treatment.

One cultural factor that plays a role in the patient-provider relationship is patient health literacy.[16] The participants in this study spoke about their experiences helping patients navigate literacy issues. A student mentioned that by envisioning their patients as family members, they communicate in a more casual way, stating, "I just kind of speak clearly, plainly; I just feel the air is just a little bit clearer." Another student told the story of a patient who, after a 30-minute neurology consultation, was left confused and unclear that he was speaking with a neurologist. The student shared that his attending physician felt the patient did not care about what he was saying. The student, however, recognized that the problem was not that the patient did not care, it was that the patient did not understand. Another example came from a student who noticed a patient was not receiving needed information after giving birth to a child with a congenital condition. She explained:

The doctors at the hospital weren't communicating with them well. She didn't understand what was going on. Nobody was really breaking down the illness in a way that the parents could understand. So, I literally spent 30 minutes explaining to them what it was, what the condition was that their daughter had, and she [asked], "Why didn't anybody say it like that?"

Many participants discussed the intimate knowledge learned from shared cultural understandings in their own communities. They emphasized that they are more likely to learn and adapt to other communities based on their own experiences of culture. The participants in this study seemed to have an innate understanding of how to incorporate and adapt information for their patients and their patients' families—a skill that students suggested they plan to develop in their careers. As one student noted, "As a physician, I'll be able to not only understand my community, but make sure I can understand everybody else's community, because I know what it's like to be misunderstood, and I know the implications of that." The participants' abilities to understand cultural and linguistic needs are indicative of a natural inclination toward providing culturally competent patient-centered care.

While a shift has occurred toward patient-centered communication, a paternalistic communication style persists among providers with racial biases.[17] These biases include asking patients of color fewer questions, dominating conversations, and making decisions for patients without patient consultation.[17,18] The participants in this study indicated that their disruption of medicine's paternalistic approach to communication is deliberate and based on the ineffective interactions they have witnessed when White physicians speak to Black patients. An attending physician suggested that rather than learning to communicate effectively, their White colleagues would give up on their patients (or no longer try to understand them). Another attending physician noted, that "Some of them [White professors] didn't really understand the [Black] culture. They never understood and they never took the time to understand why this patient would do the things they did."

DISCUSSION

Previous studies of Black/African American physicians found that their identity is tied to their "racial/ethnic community and the interconnectedness between their personal and professional identities."[8] This study clearly shows that the experiences of these Black/African American attending physicians, residents, and medical students do not fit the dominant perspectives of professional identity literature,[19] especially regarding how communication is viewed as a marker of professionalism. Participants in this study approached patients in a culturally reflective way because they understood that the health care system is challenging for Black/African American patients, and they wanted to create a sense of community and safety. In doing so, their communication took on a more familial and conversational style that centers the patient and their experiences.

Medical education has historical roots in racism and discrimination,[20,21] and structural racism persists in medical education today.[22] Indeed, the participants in this study demonstrated ways in which Black/African American patients may be dismissed and thought to be disengaged with their health care. Research has shown that culture influences the ways in which physicians communicate with their patients.[23,24] These participants' experiences highlighted how a failure to understand culture and cultural factors can lead to miscommunication, problematic patient-provider interactions, and negative health outcomes. Further, their experiences underscored the problematic socialization to professional identity formation in medicine. By communicating in a personal, reflective, and familial way with their Black patients, the participants in this study challenged ideas about what communicating as a physician means within a system that understands professional identity within the context of being a White, non-Latino man.[25]

Approaching patients with a familial and personal style of communication is linked to improved quality of care. Studies have found that racial concordance, which is "shared identity between a physician and a patient,"[26] contributes to better patient outcomes.[27] A patient's perceived similarity to their physician specifically impacts patient outcomes in the domains of physician-patient communication satisfaction, information-giving, partnership-building, visit length, supportive conversation, trust, utilization of services, and participatory decision-making.[26,28,29] Further, patients who perceive themselves as being more similar to their physician, including in the ways in which they communicate, have reported greater satisfaction with their care and a stronger intent to adhere to treatment recommendations.[27]

Code-switching is one way in which people engage in patient-centered, concordant communication. Code-switching enables physicians to communicate in a more easily understood manner—one that sounds more like the language used by the patient—and it can be used to enhance patient understanding and build rapport.[30] The participants in this study appeared to be engaging in code-switching, as a means of sidestepping the paternalistic nature of

communication, with Black patients in favor of more patient-centered communication. These participants explained that by taking a more patient-centered approach that favors relational communication, they could emotionally connect with patients in ways that facilitated the clinical encounter on their terms, rather than by doing only what they learned in their limited training.

This study highlights the role of communication in helping Black/African American attending physicians, residents, and medical students engage and connect with their Black patients. While this study offers important contributions to the literature, it has some limitations. First, this sample is a snowball sample originating with the authors' personal and professional networks. While snowball sampling is frequently used in qualitative studies, concerns exist about the diversity of samples and potential bias from "hidden populations."[31] However, the purpose of qualitative research is not generalizability, but rather a deep and rich understanding of a phenomenon.[32] A second limitation is that while this study's participants found viewing and communicating with their Black patients as family members helpful, doing so may not always be helpful. Just as treating family members can lead to role confusion and competing expectations for the physician,[33] possibly treating patients like family can lead to similar issues. Future research should explore the potential consequences of treating patients like family. A third limitation is that this study did not look at the subspecialities of the attending physicians, residents, or medical students. Family physicians often pride themselves on their ability to talk to patients—to be both good listeners and good explainers.[34] Indeed, research has found that family physicians engage in more psychosocial discussions and demonstrate greater empathy and reassurance to patients.[35] Future studies should consider subspeciality to determine specific gaps in communication training and to better understand how members of that specialty are socialized to the field. Lastly, this paper does not explore the impact of the participants' communication on patient outcomes. Future research should examine the effects of patient-centered communication on Black/African American patient outcomes.

CONCLUSIONS

This study suggests that Black/African American attending physicians, residents, and medical students approach communication from a personal and familial space, which is not reflective of medical school training. Medical education should consider strategically incorporating experiential training on patient-centered communication[36] that teaches about cultural competency, code-switching, relationship development, and trust-building. Enabling students to learn paternalistic forms of communication limits their understandings of both professionalism and communication. This antiquated communication style training has long-term negative impacts for patients and communities. This study shows how the intentional disruption of discriminatory communication is one way in which Black/African American providers are engaged in resistance from within the system[37] and how this patient-centered approach to communication creates safe spaces for Black/African American and other marginalized patients who have historically struggled with the health care system.[7,38] By communicating with patients in a familial, personal, and more vulnerable way, providers can transform medical outcomes for their community.

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