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RESEARCH BRIEF

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Opportunities and challenges in discussing racism during primary care visits

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Abstract

Objective: To understand how patients and primary care practitioners (PCPs) discuss racism and their perspectives on having these conversations during primary care visits.

Data Sources/Study Setting: We conducted semi-structured interviews from September 2020–March 2021 at a Federally Qualified Health Center in the San Francisco Bay Area.

Study Design: We conducted an inductive qualitative descriptive pilot study using one-on-one, semi-structured interviews with 5 members of a Patient Advisory Council and 10 internal medicine PCPs.

Data Collection/Extraction Methods: Interviews were conducted via video conferencing, recorded, and transcribed. An iterative analytic process was used to thematically assess participants' experiences and perspectives and identify key themes.

Principal Findings: Patients and PCPs identified benefits from engaging in conversations about racism during primary care visits and noted challenges and concerns. Patients and PCPs highlighted strategies to advance communication about racism in primary care.

Conclusions: Initiating conversations about racism with patients in primary care can be meaningful, but also has risks. More research is needed for deeper exploration of patients' perspectives and development of trainings. Improving how PCPs communicate with patients about racism represents an opportunity to advance antiracism in medicine and improve health outcomes for individuals who have historically been poorly served by our health care system.

KEYWORDS
anti-racism, health care disparities, health equity, patient-physician communication, primary care

What is known on this topic

- Racism is the root cause of health and health care inequities experienced by Black/African American, Indigenous, and people of color (BIPOC) communities.
- Experiences of racism represent a form of trauma. High-quality communication between patients and their primary care practitioners (PCPs) is important, including conversations about trauma and other psychosocial aspects of care.

- Institutions of medicine have embraced racist ideas, which are embedded in medical education and practice. An understanding of structural racism is not ubiquitous among physicians.

What this study adds

- Both patients and PCPs are open to and see value in discussing race and racism during primary care visits.
- Conversations about racism represent an opportunity for patients to feel understood and for PCPs to demonstrate allyship and trustworthiness. Challenges include lack of time, poor communication, and perpetuating trauma.
- Opportunities to support these conversations include communication trainings, availability of racially concordant PCPs for BIPOC patients, and inclusion of diverse perspectives in future research and interventions.

1 | INTRODUCTION

Black/African American, Indigenous, and people of color (BIPOC) communities experience a disproportionate burden of disease and shorter life-expectancy.[1,2] Racism is the root cause of such racial and ethnic inequities in health outcomes.[3–8] Racism impacts health by disproportionately exposing BIPOC to inferior health care quality and access, poverty, police violence, psychosocial trauma, environmental and occupational health risks, bias and discrimination, and other stressors.[9–11]

Racism is not a new phenomenon, rather it is deeply engrained in U.S. history and society. However, the COVID-19 pandemic, the murder of George Floyd, other acts of state-sanctioned racist violence, and the white nationalism embraced by the Trump presidency focused mainstream societal attention on naming and dismantling racism.[12–14] Indeed, there is growing discussion within medical communities recognizing the experience of racism as a form of trauma that health care practitioners should be prepared to address with patients.[15–17]

The importance of high-quality patient-practitioner communication focused on psychosocial aspects has been well-established.[18,19] Recent articles have explored the idea of discussing experiences of racism with patients and emphasized the need to equip clinicians with the skills to engage in these conversations.[20–24] A recent study by McCuistian and colleagues explored how a primary care-based integrated behavioral health team perceived the impact of racism on patients and the implementation of posttraumatic stress disorder treatment.[25] Although limited to health care providers' perspectives, their findings highlight the importance of considering the impacts of racism and discrimination in health care delivery and recognizing racism as a potential barrier to treatment planning. There remains a critical need for research to understand whether and how patients and primary care practitioners (PCPs) discuss racism.

In the present study, we sought to explore PCPs' and BIPOC patients' experiences and perspectives on having conversations about racism during primary care visits.

2 | METHODS

2.1 | Study design

We conducted semi-structured interviews with PCPs and patients from September 2020 to March 2021. Our analysis employed an inductive qualitative approach. All study procedures were approved by the institutional review board at the University of California San Francisco (IRB No. 20-30,480).

2.2 | Participants and recruitment

Study participants included patients and PCPs. Patient participants were adults who receive primary care at a Federally Qualified Health Center (FQHC) in the San Francisco Bay Area and serve on one of the FQHC's Patient Advisory Councils (PACs). The PACs are volunteer groups that meet regularly to provide feedback to the clinic. Any PAC member who self-identified with a racial/ethnic group other than White and spoke English was eligible to participate in this study. A study researcher attended a PAC meeting and invited PAC members to participate in the study. PCP participants were physicians and nurse practitioners at an FQHC. All PCPs who practiced in the clinic were eligible to participate; the medical director sent an email to all providers and invited their participation. The PCP and PAC participants were all associated with the same health system but worked at different clinics within the same building. The clinic from which PCPs were recruited did not have an active PAC, so patients were recruited from another primary care clinic's PAC within the health system.

2.3 | Data collection

Interviews were conducted by one investigator (HMB) via Zoom videoconferencing and were audio recorded.[26] The interview started with the receipt of verbal informed consent and the completion of a

TABLE 1 Semi-structured interview guides

Patient interview guide	Primary care practitioner interview guide
• What are the identities that are important to you? • How do you think race or racism affects your health? • What experiences have you had in health care where you were treated differently because of your race? • How do you feel about talking with your health care practitioner about race or racism? • How would you like that conversation to go? • What do you hope would result from this conversation? • What concerns would you have about having this kind of conversation? • What would make you feel more or less comfortable with having a conversation about race or racism? • What do you wish your health care practitioner understood about race/racism and your experience? • What advice would you give to health care practitioners when having conversations about race/racism and health with their patients?	• What are the identities that are important to you as a primary care practitioner? • How do you think racism affects your patients' health? • What are your thoughts on engaging in a conversation about racism with a patient during a primary care clinic visit? • What would lead you to consider initiating a conversation about experiences of racism with a patient? • What benefits do you perceive in engaging in a conversation about racism with a patient? • What concerns would you have in engaging in this conversation with a patient? • How would you feel if a patient initiated a conversation with you about an experience of racism? • How would you respond if a patient shares that they are experiencing or have experienced racism? • Tell me about a time you wanted to discuss racism with a patient, but did not? • How does your personal background, including your own racial/ethnic identity as well as other identities you hold, impact how you engage or do not engage in conversations about racism with patients?

Note: Additional probing questions were asked depending on participants' responses.

brief demographic survey. All participants were asked to report their race/ethnicity, gender, age, and educational background. PCPs were also asked to provide their number of years in practice and whether they had ever participated in health-equity-related training.

The research team developed two separate semi-structured interview guides (Table 1). Development of interview questions was informed by existing work exploring how to talk about racism and other forms of discrimination with patients.[15,16,22–24] Interview questions were framed to be intentionally open, and study participants were free to share experiences of discussing racism at any level—internalized, personally mediated, and/or institutional racism.[27] The patient interview guide was revised after the first interview, and the PCP interview guide was revised after pilot interviews with two fourth-year medical students.

Each interview began with the interviewer (HMB), a White woman, sharing her own racial and gender identities and personal motivation for engaging in health equity research. This approach recognizes the "location of self," which helps build rapport, earn trust, and acknowledge identity differences.[28]

2.4 | Data analysis

All interviews were transcribed verbatim by a transcriptionist and imported into Dedoose-8.3.45. Transcripts were analyzed using standard techniques based on grounded theory,[29] which allowed for inductive content analysis whereby themes emerged from the data.[30] An initial codebook was developed based on 3 patient transcripts and 5 PCP transcripts. Codes were agreed upon by the team and iteratively revised as additional transcripts were coded. All transcripts were independently coded and discussed by two authors. Coding discrepancies were discussed among the research team to reach a consensus. We identified themes that emerged from patients' and PCPs' responses.

The members of the research team represented diverse clinical and research backgrounds, including internal medicine, pediatrics, nursing, health communication, and qualitative research. Further, the research team included diverse racial/ethnic identities. Throughout the research process, the team engaged in reflexive practices to understand how each member's identities and experiences affected their interpretation and reaction to the data.

3 | RESULTS

Study participants included 5 patients and 10 PCPs (Table 2). Four key themes emerged—contexts for conversations about racism in primary care; potential benefits; challenges and concerns; and strategies for improvement.

3.1 | Theme 1: Different contexts for conversations about racism in primary care

Most patients could not recall a specific time they had discussed racism with their PCP but they shared personal experiences of racism inside and outside of health care settings. For example, when asked about a time they experienced racism, patients described being denied pain medications, being treated harshly and without empathy in clinic waiting rooms, and experiencing discrimination in the workplace. Generally, patients were interested in discussing these experiences with their PCP.

Although most patient participants did not recall discussing racism with their PCPs, most PCPs reported that they had engaged in conversations about racism with patients, which arose in three subthemes (Table 3).

TABLE 2 Participant characteristics

	Patients ($N = 5$) *n* (%)	PCPs ($N = 10$) *n* (%)
Race/ethnicity		
White (non-Latinx)	–	6 (60)
African American/Black	4 (80)	1 (10)
Latinx	1 (20)	–
Asian	–	3 (30)
Native American/American Indian	1 (20)	–
Gender identity		
Female	4 (80)	9 (90)
Male	1 (20)	1 (10)
Educational background		
Some college/no degree	2 (40)	–
Associate degree/trade/vocational school	1 (10)	–
College graduate (Bachelor's degree)	2 (40)	–
Age (M, SD)	59 (2.92)	–
Medical training background		
MD	–	9 (90)
NP	–	1 (10)
Ever participated in health equity-related training	–	10 (100)
Years since completed health professions degree (M, SD, Range 9–31)	–	18.6 (7.6)

Note: Race/ethnicity category adds up to more than 100% because respondents could select multiple racial/ethnic identities, as applicable.
Abbreviation: PCPs, primary care practitioners.

3.1.1 | Patients' experiences of racism in health care

All PCPs spoke of the immense amount of racism their patients experienced within health care settings. Several PCPs reported that they routinely ask patients if they had ever experienced discrimination within the medical system. PCPs also described processing negative experiences in health care settings with patients and acknowledging the contribution of racism.

3.1.2 | Acknowledging present-day racism conveyed in the media

Racism manifested in current events prompted many PCPs to initiate a conversation with patients about racial trauma and its impacts on health. PCPs identified the murder of George Floyd and protests during the summer of 2020 as motivation to initiate conversations about racism with patients.

3.1.3 | Acknowledging patient-PCP racial identity discordance

PCPs recognized and reported openly discussing racial identity differences between themselves and their patients. One PCP described talking with patients about how having a White PCP might feel challenging. Another PCP recalled a specific relationship in which they wished they had more openly discussed racial discordance between themself and a patient.

3.2 | Theme 2: Potential benefits

Both patients and PCPs identified potential benefits from engaging in conversations about racism in primary care (Table 3).

3.2.1 | Patients feel understood and heard

Patients underscored the value of having the opportunity to talk with their PCP about their life and experiences outside of the strict medical agenda. Their goal in discussing racism with their PCP was to feel heard.

3.2.2 | PCPs gain an understanding of patients' lives

Many PCPs felt that discussing racism with patients could build trust and allow them to gain a deeper understanding of the realities of their patients' lives.

3.2.3 | PCPs demonstrate allyship and trustworthiness

Many PCPs sought to illustrate to their patients that they cared about racial justice. PCPs also wanted their patients to feel comfortable raising such concerns during medical visits.

3.3 | Theme 3: Challenges and concerns

While patients and PCPs were open to engaging in conversations about racism, both groups noted challenges and had reservations about if and how these conversations should be conducted (Table 3).

3.3.1 | Lack of time

By far, the most commonly noted concern by patients was lack of time to engage in a conversation about racism during an already time-constrained visit with their PCP. PCPs shared this concern and cited

TABLE 3 Representative quotes by theme

Theme 1: Different contexts for conversations about racism in primary care	
Discussing patients' prior experiences of racism in health care settings	*"Usually if I ask people if they have been disrespected or discriminated against or treated badly in the medical system in any way, people will start to tell you what's been awful, and you know how to behave in a better way."* PCP 2 *"I was recently talking to one of my primary care patients who had gotten a random U-tox in the ER and was really triggered and traumatized by that. And she was just kind of talking about it in the sense of like being mistreated and not feeling like that was the right thing. And I was just like, do you also feel like they did that because you are a Black woman?… And she was like, yes. And we were able to just kind of call that out and say yeah, that does happen. That does happen in practice, and I'm really sorry that that happened. And we need to talk about how you feel about that because I think it prevented her from wanting to get additional care in the emergency room."* PCP 10
Acknowledging present-day racism conveyed in the media	*"Well, especially after George Floyd I did [engage in a conversation about racism with patients]… And in those weeks to months after… I felt like I was hosting a lot of those conversations. And it was kind of the current events being a segue into their personal experience, not just like hey, what do you think about this? Or is not this awful? But more so being able to be honest."* PCP 3 *"I would say how are you holding up? And they'd go, yeah. And I would go, yeah. Rough times, right? Rough times, it's getting crazy in this country. You know. How are you dealing with that? And then I would just listen… A brief moment to air out and not necessarily in a long-winded way, but just to sort of say yeah, it's been stressful. This is crazy, and sort of leave it open ended and they share."* PCP 8
Recognizing patient-PCP racial identity discordance	*"There have been times where I've…just asked patients, there's a lot of racism in medicine and in our society, is it hard for you having a White physician? I'm very up front about that."* PCP 6 *"…it seemed to me that like me being White and him being Black should be something that I should have discussed… just acknowledging that power differential or that dynamic and exploring whether it affected his interest in continuing to engage."* PCP 3
Theme 2: Potential benefits	
Patients to feel understood and listened to	*"Well, for me it's all about just having someone's ear. You know what I mean? No one may be able to help me, but for me to be able to express it and express my frustration, talk about it, can be easing, you know what I mean? Can take a lot of the pressure off, and I just feel good about talking about things."* Patient 5
Opportunity for PCPs to gain an understanding of patients' lives	*"I think [talking to patients about race and racism is] like untapped potential to know your patients better and know the things that are important to their life…The more you know a person as an individual, as a person, and everything that they bring, the better you can be as their doctor and the better their health can be as a result of that. So whether it's like understanding their home environment, their neighborhood, their interactions with their local pharmacist, their interactions when they come to our ED, I think it helps me to know enough about their care so I can tailor things to them and it helps them to know that I know and that I care."* PCP 9
Opportunity for PCPs to demonstrate allyship and trustworthiness.	*"And I guess my primary goal of having those conversations was to acknowledge my patients' experience and to identify myself as an ally… I am somebody who potentially they could talk to if there were issues going on. I think there's a lot of benefit in patients feeling seen, and so I think in some ways that was a benefit."* PCP 8
Theme 3: Challenges and concerns	
Communication challenges	*"Will they listen? Will they show some concern? You know? Even though they may not be able to do anything about it, but just show some concern…If they say well, there's nothing you can do about it so get over it. I mean, that would be the worst…Or you just be concerned about your health, do not you worry about that."* Patient 2 *"I think that for me, talking about race can sometimes feel like it's fraught. So frequently there is a sort of worry that I'll get it wrong, and not wanting to take that chance with a patient interaction. I might be more cautious maybe than in some cases I should, and I do not necessarily have the answer to that."* PCP 5
Patients may not want to talk about racism with their PCP.	*"…racism is a personal experience, in that you do not always want to talk about it… You might not want to talk about it with too many people period, or with your doctor or anyone else… and then like no matter where you are, everyone wants to talk about race and racism with people that are Black… that's my concern, if it's not done with skill, knowing when to broach that, when to let someone else bring it up and how you broach that, it's so personal and varied by people that it could be harmful."* PCP 8
Bidirectional risk of perpetuating trauma	*"I think there also needs to be a humility about like when and how you talk about racism as someone who is of the oppressor identity, rather than the oppressed… I could be perpetuating like a power identity by bringing up racism without having established like rapport and being behaving in a trustworthy way first, as a White person."* PCP 2

TABLE 3 (Continued)

Theme 3: Challenges and concerns	
	"I think that the aspects of my identity that help me relate in some way to an experience of racism also can serve to make me hesitant to engage in some of the hard discussions that we sometimes want to have with patients. It cuts both ways." PCP 5
Lack of time	*"I think that takes up too much of the doctor's time. So primary care for me mentally is health-wise. Explaining more about how come you all doing all these different tests on me? How come you are all going through this? What does it mean?"* Patient 1 *"…there's always so much stuff we have to talk about and I do not have that much time. So engaging in a discussion about racism like would just, I would love to do it, it just would take a long time."* PCP 1
Theme 4: Strategies for improvement	
Communication training	*"I'll say sometimes health conditions can be affected by stress… There's a lot of different ways in which people experience stress, and I'm happy to talk about that further, but I just wanted to make sure that conversation would be OK with you….I'll be like, what's going on after this? Do you need to get out of this appointment right then? Is your parking going to run out?… I was going to talk to you about a conversation, but it's going to be a little long. Do you have time for that today? I think it's going to be helpful for our relationship and for your health, but tell me about where you are at with that."* PCP 10 *"I think one of the things we are touching upon is that the more like actual true respect and ceding of power and viewing yourself, knowing that the power dynamic is there as a provider versus a patient, and knowing that the power dynamic there as a White person, what are the ways in which you signal from the very beginning of every visit in the way you interact with people that you are not trying to be coercive or be careless with power…"* PCP 2
Recognizing the potential value of racially concordant patient-PCP relationships for BIPOC patients	*"I probably would not have brought something racial up to [my White male PCP] at the very beginning, because I did not know him. Like I did not know his heart… I would not have brought it up because I would not know where his sympathy lay… I know I would have spoken to [my previous Black female PCP] about it probably fairly quickly… when you think about it, I had a Black woman and now I have a White male, but they are kind of the same… They're both great doctors. But I'm sure it would have been easier to talk to [my previous Black female PCP about race]."* Patient 3 *"I think being willing to just assume that based on your positionality and based on your identity, there's probably a lot that your patients aren't telling you… So I think assuming you are not hearing the whole story if you do not share a particular identity with a patient is important, being willing to make it possible and feasible for patients to transfer their care from one provider to another if they do not feel respected."* PCP 2
Allow diverse perspectives to inform this work	*"I feel like we often talk to each other about what solutions we are going to have, and I'm like, we are missing a lot of voices at this table. And it's not just like getting other doctors or other healthcare providers at the table. It's about reaching out beyond that."* PCP 10

Abbreviation: PCP, primary care practitioner.

the numerous items they are expected to address during a 15-min preventive care visit.

3.3.2 | Communication challenges

Patients and PCPs raised concerns as to whether a PCP was the best person to host a conversation about racism. Some patients wondered if the topic might be better suited for a behavioral health specialist. Other patients worried their PCP might invalidate their concerns or deny their experience of racism.

PCPs also feared many clinicians are poorly equipped to skillfully host a conversation about racism and they worried about the risks of broaching such a sensitive and potentially traumatic topic.

Several PCPs identified language barriers as another challenge. Some noted they were far less likely to open a conversation about racism during patient encounters which involved an interpreter, fearing they may not properly convey themselves in broaching this complex topic.

3.3.3 | Patients may not want to talk about racism with their PCP

Several patients acknowledged that everyone is different—while some patients may want to talk with their PCP about racism, others might be more reluctant. Patients also noted potential generational differences in the way BIPOC patients may want to engage in this topic.

Multiple PCPs worried that discussing racism might be unexpected and force patients to have a sensitive conversation without their consent, and others noted the conversation could feel irrelevant or intrusive.

3.3.4 | Bidirectional risk of perpetuating trauma

PCPs also worried about inadvertently perpetuating racism and evoking triggers associated with patients' experiences of cultural, racial/ethnic, and historical trauma. PCPs recognized potentially greater risks involved in talking about racism with patients who did

not share their same racial identity, noting that White PCPs will likely require significant anti-racism education to be equipped for such conversations.

PCPs also recognized the risk of vicarious trauma for BIPOC clinicians who engage in these conversations since it may be helpful, yet particularly distressing, to relate to a patient's experience of racism.

3.4 | Theme 4: Strategies for improvement

Patients and PCPs identified strategies needed to advance this work (Table 3).

3.4.1 | Communication training

PCPs underscored the need for training clinicians on how to communicate with patients about racism. PCPs identified key communication practices, including (1) asking patients for permission to initiate a conversation; (2) approaching the conversation with attentiveness, humility, and curiosity; and (3) disrupting power dynamics between patients and PCPs.

3.4.2 | Racially concordant patient-PCP relationships for BIPOC patients

Uniformly, patients reported openness to talk about racism with a PCP who did not share their racial identity. However, several patients noted they would feel more comfortable with racially concordant clinicians. PCPs also reported the benefit of racially concordant patient-PCP relationships for BIPOC patients and wished more patients had this option.

3.4.3 | Diverse perspectives needed

PCPs were highly interested in this topic, including practice guidelines and research on the impact. They stressed the importance of including a broad range of stakeholders, such as patients, community members, and social workers.

4 | DISCUSSION

Our study describes the experiences and perspectives of patients and PCPs on engaging in conversations about racism during primary care visits. We found that patients and PCPs are open to talking about racism during clinical encounters, described potential benefits, identified notable challenges, and highlighted strategies and tools needed to ensure meaningful discussions. For PCPs who navigate conversations about racism with patients and support trainees who engage in these conversations, our findings support the application of relationship-centered communication, critical race theory, and trauma-informed care to this work.

Participants noted the importance of applying principles of relationship-centered communication (RCC) to these conversations.[31] While RCC can guide PCPs' approach to conversations with patients on a range of different topics, it is particularly crucial for conversations about racism. PCPs can apply RCC by sharing power with patients in navigating the visit, asking open-ended questions, engaging in active listening, recognizing patients' emotions, and responding with empathy.

The challenges and concerns raised by our participants highlight the thoughtfulness necessary to engage in conversations about racism. Saha and Cooper outline common communication mistakes in discussing racism, including doubting patients' experiences, expressing surprise, which conveys a lack of awareness of the widespread prevalence of racism, and offering qualifications or excuses to defend racist behavior.[23] While noting the negative impact of communication mistakes, the authors also highlight the consequences of physicians' silence.

We note that in our study, the majority of patients could not recall a specific time they discussed racism with their PCP. It is possible that PCPs and patients have different perceptions as to what constitutes a conversation about racism and we speculate that PCPs may broach the topic indirectly, in ways that may not resonate with patients.

As compared to the national population of PCPs, our participants may have been more open to discussing racism with patients, given their work at an FQHC which serves a large population of BIPOC patients, prior health equity training, and interest in our study. High levels of structural competency—an understanding of how economic, social, and political structures (such as racism) create inequities between individuals[32]––is not widespread among health care professionals.[33,34] When asked to explain racial health disparities, physicians often blame patients rather than acknowledging structural barriers within our health care system.[35] These results are emblematic of the racist ideas that are deeply embedded within medicine, raising concerns about clinicians' preparedness to host conversations about racism with patients.

Indeed, the PCPs in our study underscored the significant amount of anti-racism education that PCPs need, especially White PCPs, to skillfully engage with patients. BIPOC PCPs who participated in our study also expressed their own need for training and support, which may differ from the training required by White PCPs. Ultimately, we believe it is essential to incorporate critical race theory into medical education. Throughout every element of medical education, this will involve explicitly recognizing how racism is operating, centering on the perspectives of marginalized groups, and understanding how racism creates power hierarchies.[36] Promising examples of incorporating critical race theory into medical education include structural competency curriculum,[37] equipping medical educators with the skills to appropriately address microaggressions,[38] and trainings on practicing antiracism in the exam room.[39]

PCPs were also concerned that discussing racism with patients could evoke trauma. Diop and colleagues offer trauma-informed care

as a guiding framework for approaching conversations about racism with patients.[22] Key tenants of trauma-informed care include understanding what makes patients feel physically and psychologically safe, working to achieve safety, as defined by patients, and identifying and building upon patients' strengths.[40] Diop and colleagues note that clinicians can engage in a conversation about patients' experience of racism without requiring the patient to disclose details of what happened, which can be re-traumatizing.[22]

Our pilot study represents an initial exploration of this important topic and has several limitations. First, while our study demonstrated the feasibility of using qualitative methods to explore this topic and yielded important insights, thematic saturation was not reached. Secondly, the majority of PCP participants were White, and all racial/ethnic minority groups were not represented. Thirdly, interviews with patient participants were conducted by a racially discordant interviewer. However, prior research suggests that barriers related to racial discordance between researchers and study participants can be overcome through relationship building.[41] Further, the racial and ethnic diversity of our research team represents an important strength of our study. Finally, the characteristics of our patient and PCP participants may limit transferability. Because we selected patients from a patient advisory council, they may have a more positive relationship with the health care system than other patients, feel more empowered to share opinions, and be more likely to provide feedback to providers. Further, all PCP participants had participated in anti-racism trainings which does not reflect PCPs across the country. Qualitative data is not intended to be generalizable, but rather used to explore phenomena that are not yet well understood, as we have done in this study.[42]

In conclusion, among a small sample of patients and PCPs within an FQHC, all recognized the value of discussing racism in primary care but noted that engaging in these conversations has inherent risks and may not be appropriate for every patient nor PCP. Efforts to support PCPs in engaging in these conversations should be based on relationship-centered communication, critical race theory, and trauma-informed care. Future studies should explore patients' perspectives on discussing racism in a large, diverse sample that can inform the development of guidelines and tools for PCPs.

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